			1 - For State Registrar	State of Maryla	•	artment of H		ind Mental	Hygier	000	1 =	25001
			Registrar 1. Decedent's Name (First, Middle, Last)			rimoate of L	Journ	2. Date Mont	of Death	oay	Yeer	3. Time of Death
	Physici /Medic			Noah A. Del	awder			JUI	Y 14T	H, 20	05	22:05 M
, the	Examin	er	4a. Facility Name (If not institution, give s MEMORIAL HOSPITAL	treet and number)		4b. City, Town, or CUMBERL		t Death		tc. County of		
	Funeral		5. Social Security Number 6. Sex	M 0005	rs. last birthday)	If Under 1 Year Months Days	If Under 2 Hours	Min. (Mon	of Birth h, Day, Yea	ır)	9. Birthp	lace (State or Foreign
H	Director		220-12-3913 Usual Residence of Decedent	8	2 Yrs.			Ap	oril 22,	1923	virg	inia
	aryland show	_	10a, State 10b. County		City, Town or Lo						1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the Market	Funeral Directo	Maryland Alle	gany	-	10f. Zip Code	umbe	erland	10g. (Citizen of W	/hat Cour	
	h with	I DI		on St., Apt. 1			215	02			U	SA
	ams 2	iner		12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Orig n, Mexican	gin? (Specify Yes , Puerto Rican, et	or No-		Americ k, White,	an Indian, etc.
36	72 hours after death with the Maryland natural; or itams 23s or 28s-f show deat Exacultust and be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ⊠Yes 2 ☐ No If Yes, Give Year or Dates: 194		1 ☐ Yes 2 ☐ No	Specify:			Specify:	:	White
2-00	72 hou natura	ted	15. Decedent's Educ	cation	16a. Dece	dent's Usual Occupa		of working	16b.	Kind of Bu	siness/Inc	
21	vithin 7.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	irfe.	DO NOT use retired,	nardn				Orcl	nard
d 2	e filed within al Hygiene. cother than "		17. Father's Name (First, Middle, Last)			Ofti		r's Name <i>(First, N</i>	liddle, Maid	en Sumam		liaru
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. If item 27 is marked other than "natural; or itams 23a or 28a-f show or other traumatic event, If a Madical Extracting 1 and be notified at	To Be	Laı	m Delawder						ı (Ree		
Mar	nd 2 sho Ith and 27 is m traum		19a. Informant's Name/Relationship (Type Fran Garlitz/		19b. Maili	ng Address (Street a		r or Rural Route I r St., Cur				
	s 1 and f Health item 27 othar to	1 3	20a. Method of Disposition	206	cametery cre	osition (Name of	a)	Date	20c.	Location -		
m 0	Page: nent o int: if		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Re	estlawn N	Memorial G	arden	s 7/18/0	5	La	Vale	, MD
Baltimore,	permit. Pages 1 an Department of Heal important: if item 2 any injury or othar once.		21. Signature of Fuperal Service Libense	A	2:	2. Name and Addres			ght Fu			
	40 E # 0		23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	ations that caused the de	eath. Do not en	309-3 ter the mode of dying	11 De	catur St.,	Cum ory arrest,	berlar	ıd, M	Approximate
100	Pnysician :		Immediate Cause (Final	Coronar	y Δv.			ease				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a cons	notience of):	ter A		صريات				syeris
W.	Examiner	Į.	Sequentially list conditions, if any, leading to immediate cause. Enter uncertainty	. Due to (or as e cons	equence of):						_	
Т	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events									
0,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a cons	equence of):							
8760,	death certificate be executed e attending physician and d for use as the burial-transit	dical										
Вох 6	eath certific attending pl	lan/Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pred		75				23d. Date	e of delive	,
.O. B		sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 2 ☐Fi 4☐Pregnant at time o 9☐Unknown		□Ectopic pregnancy □ Other (specify)			_	Mor	nth	Day Year
Ρ.	t the	Physic	9 ☐ Unknown Part II. Other significant conditions con	tributing to death but not	resulting in the u	inderlying cause give	en in Part I.	23e	Did tobacc	o use contr	ibute to th	ne cause of death?
Vital Records,		d by						_	1 🗆 Yes	2 🗆 No	3 🗌 Prob	ably 4 🛣 Unknown
000	e law requires has been sign ge 2 should be	Completed						24a.	Was an autopsy	p	Vere auto	psy findings available impletion of cause of
E R	The ate has page	Com						1 🗆	performed'	d	leath?	
Vita	Physician: The this certificate al director, page	Be	25. Was case referred to medical examiner?	ospital:	☐ ER/Outpatie	othe Othe	25	of Death (Check		c Corb	- (C	
of		n: To	1 ☐ Yes 2 🛣 No 27. Manner of Death	1 Inpatient 2 28a. Date of Injury (Month, Day Year,		IL 3 LI DOA	/ at		cribe how in			//
sion	Attending F r death. actor: After by the funer	atlo	1 Natural 5 Pending investigation	(WOILIT, Day Tolar,	injury		Yes 2 1					
Division	i or Attendate death Diractor:	ertification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, st ecify)	reel, factory, office			tion (Street or Town, St		er or Rura	l Route Number,
	To the Hospital or At within 24 hours after or To tha Funeral Dirac completely filled in by	edical C	29a. Certifier 15 Certifying Physical Check only 2 Medicel Examinate	sician: To the best of my later: On the basis of exame and manner stated.	knowledge, dealination and/or in	th occurred at the time	ne, date and pinion, deat	d place, and due t th occurred at the	o the cause time, date a	(s) and mai	nner as si	tated. the cause(s)
	To the k within 2 To tha R	Med	29b. Signature and title of certifier	1		29c. License	number		29d. (Date signed	(Month,	Day, Year)
			1	python		D33	280		In	413	,20	05
	43		30. Name and address of person who co	/			101	Ola Cara	AND	MD 01	E00	
	Sta	ite	GUPTA, SUNIL K., I	M.D., 625 KE 32. Registrar's Sig	NT AVEN	UE, SUITE	101,	COMREKI	AND,	MD 21	502	
	Regist		JUL 1 8 20	005 Lineur	M. A	front?						

			For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F ertificate of		Mental Hy	giene Reg. N.2 0	05	25002
L	Physici		Decedent's Name (First, Middle, Last) DELLA VIRGINIA					2. Date of D	Day	Year 2005	3. Time of Death 6.45 AM
>	/Medio		4a. Facility Name (If not institution, give	street and number)			r Location of Deatl		4c. Coun	ty of Death	1
			Memorial Hosp 5. Social Security Number 6. Sec		ge (In yrs. last birthday	Easto If Under 1 Year	If Under 24 Hrs.	8. Date of B	1a	9. Birth	place (State or Foreign
u	Funeral Director		219-32-1267]M 2 ∑ F	86 Yrs.	Months Days	Hours Min.	FEB 12	1919	MAJ	RYLAND
	pu s		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation			-		10d. Inside City Limits
	Maryia f eho	ō	MD TALBO	т		STON					Yes 2 □ No
	r 28a-	irect	10e. Street and Number			10f. Zip Code		· · · ·	10g. Citizen o	f What Cou	ıntry?
	th with	alD	203 CHOPTANK AVE.				21601			USA	
36	be filed within 72 hours after death with the Maryland tial Hygiene. od other than "natural", or Iteme 23a or 28a-f ehow event, the Medical Exe. invertible Lodified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed WD Divorced	12. Was Decedent Armed Forces' 1XXYes 2 ☐ If Yes, Give Year or Dates:	?	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No		specify Yes or N to Rican, etc.)	14. R: Bi	lack, White	ican Indian, , etc. HITE
9	72 hou	ted	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dec	edent's Usual Occup e kind of work done	pation during most of wo	rkina	16b. Kind of	Business/l	ndustry
21215-0036	within 7 ene. than "r	Completed	Elementary/Secondary (0-12)	College (1-4or	5+) life.	DO NOT use retire	d)	9	DDTILL		TY NUDGING
	e filed within al Hygiene. other than vent, the Me		17. Father's Name (First, Middle, Last)	3	KE(GISTERED :	18. Mother's Nar	me (First, Middi			TY NURSING
an	thould be ind Mental marked o	o Be	LLOYD LOWE LOMAX				LUCY 3	JONES			
lary	s 1 and 2 should f Health and Mer Item 27 ie marke other traumatic		19a. Informant's Name/Relationship (7)			ling Address (Street				m, State, Z	ip Code)
e,	fealth sm 27 sm 27 sher tr		SHARON J. RITTER/ 20a. Method of Disposition	PER REP	20b. Place of Disp	BOX 1087	EASTON, I	AD 21601	20c. Location	n - City or 1	Town, State
nor	ages int of B t: if ite y or of		1 XBurial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)		cemetery, cri	ematory or other pla CEMETERY		1/2005	ST. MI	1	
Baltimore, Maryland	permit. Pages 1 an Department of Heal Important: if Item 2 any injury or other once.		21. Signature of Funeral Service Licens			22. Name and Addre	ess of Facility		1		
ä	Depariment in any in an		23a. Part1. Enter the disease, or comp	ERCER		ELLOWS, H OO S. HAR				501	Approximate
	/Medical Examiner behavioran and bhysician and street burial-transit	Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a:	sta consequence of): Self-We stack the consequence of): Ore COre s a consequence of):						Interval Between Onset and Death
68760,	sician buria			ď		/					
Вох	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnand □ Other (specify) _	У			Date of deli	very Day Year
ds, P.O.	ires that t signed by I be deta	by	Part II. Other significant conditions co	ntributing to death	but not resulting in the	underlying cause gr	ven in Part I.		I tobacco use co		the cause of death?
of Vital Records,	w require been sign	Completed	Atrial	sion Fibrila	Hon		14.0.0048	24a. Wa	ıs an 24l	o. Were au	topsy findings available
Re	e = e	dwo						aut per 1□ Yes	formed?	death?	completion of cause of
ital	ician: Th certificate rector, pag	BeC	25. Was case referred to medical				26. Place of De	ath (Check only			
> ≠<	Phyaician: this certificant all director,	To	1 Yes 2 No	Hospital: 1 Inpat		ent 3 DOA			sidence 6 🗆 C		cify)
Division (or Attending ter death. irector: After irector by the funer	Certification:	27. Manper of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	28a. Date of In (Month, D		M 1]Yes 2□No	28f. Location	Street and Nucown, State)		ral Route Number,
J	To the Hospital of within 24 hours at To the Funeral D completely filled in	edical Ce	29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exam	rsicien: To the besiner: On the basis and manners	st of my knowledge, dea of examination and/or stated.	ath occurred at the tinvestigation, in my	ime, date and plac opinion, death occ	e, and due to the	e cause(s) and e, date and plac	manner as e, and due	stated. to the cause(s)
	To the vithin To the comple	Me	29b. Signature and title of certifier		_ 2		se number		29d. Date sig		
)			> Harou L	aura St	n A		0554	84	7	- /7	-2005
3			30. Name and address of person who o								
	St	ate	HAROU LAURA JIN 31. Date filed (Month Day, Year) 200	32 Regis	S. WASHIN	GTON ST E	ASTON, MI	D_21601			

DHMH 17 Rev 1/2001

Della Dunklin

			State of Maryland / Department				9	··
			101	rtificate of D		- 1	Reg. N2 0 0 5	25003
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Dea	ath	3. Time of Death
	/Medic		Josephine Salvaggio Dorsch	T		July	15, Day 2005 Yes	
	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or L Rockville	ocation of Death		4c. County of D	
	Funeral		Casey House 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	Montgome	
	Director		211-12-7763 1	Months Days	Hours Min.	Apr. 1	1, 1923 Pe	Birthplace (State or Foreign Country) ennsylvania
	how thow	_	10a. State 10b. County 10c. City, Town or Lo	ocation				10d. Inside City Limits
	8a-f	ecto	Maryland Montgomery Gaithersbu			-		1 ☐ Yes 2 🛣 No
	a or 2		10e. Street and Number	10f. Zip Code 20879			10g. Citizen of What	Country?
	Jeath ms 23	era	18411 Guildberry Drive #101 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Yes		panic Origin? (Spec		USA 14. Race - A	merican Indian,
336	d within 72 hours after death with the Maryland Jiene. r than "natural", or liems 23a or 28a-f ahow the Macical Examiner must be mailfied at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 No		lican, etc.)	Black, W Specify: W	hite, etc.
2-0	72 ho	Completed	15. Decedent's Education 16a. Decedent's Education (Specify only highest grade completed) (Give	dent's Usual Occupation	ion		16b. Kind of Busine	
2	Atthin ne.	mple	College (1-40r 5+)	kind of work done dur DO NOT use retired)	ring most or workin	g		
22		S	12 Homen 17. Father's Name (First, Middle, Last)		8. Mother's Name	(Eimt Middle	Own Home	
ano	d be dental I	To Be	Joe Salvaggio	1	Elizabeth		·	
Maryland 21215-0036	shoul and Ma amarl umatl	ř		ng Address (Street and	d Number or Rural	Route Numbe	r, City or Town, State	e, Zip Çode)
e, K	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic evant, once.			Streamsic			burg, MD 2	
Baltimore,	Pages ent of ht: If it ry or o		I P pariet 5 M Cramation 2 P Pario at 11011 2/4/9	osition (Name of matory or other place)	_	16,	Odenton, N	
altii	permit. F Departm Importar any injur				5			•
<u> </u>	89528		Devely L. Hentle M01251 Be	verly L. I	Heckrotte	P.A.	Clarksvil	ox 784 lle, MD 21029
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a Advanced Gastric Company of the condition a Advanced Castric Company of the condition a Advanced Castric Company of the condition a Castric Company of the condition a Castric Company of the cast of th		such as cardiac or	respiratory arr	rest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	, direct				
	Laminer	_	Sequentially list conditions, I any leading to instructions Due to for as a consequence of					
	uted f insit	mIne	cause. Enter Underlying Cause (Disease or injury					
o,	te be executed ysicien and ie buriat-transit	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):					
8760,	ate be executed hysicien and the burial-transit	cal	d					
9	ertifica ling ph e as th	Med	IF FEMALE:	- 200				
Вох	death certifica e attending ph of for use as th	lan/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E	Ectopic pregnancy			23d. Date of o	delivery Day Year
P.O.	the de	ysic	1 ☐ Yes 2 🖫 No 9 ☐ Unknown 9 ☐ Unknown	Other (specify)				,
S, D	The law requires that the death certificate ate has been signed by the attending phys page 2 should be detached for use as the	by Physician/Med	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given	in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ord	w require been sig should b					1 🗆 Y	es 2√∑No 3⊡	Probably 4 Unknown
Record	law r	Completed				24a. Was a	sy prior t	autopsy findings available o completion of cause of
	n: The					performula 1 Tes		? es 2 No
<u> </u>	Phyalcian: this certifice ral director, p	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☒ No Hospital: 1 □ Inpatient 2 □ ER/Outpatient	Other	26. Place of Death (hospino
1 0 (g Phy er this eral d	n; To	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at	4 Nursing Home		ence 64 Other (S _E ow injury occurred	hospice hospice
ior	Attending or death. ector: After by the fune	atlo	1 🕅 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes	s 2□No			
Division of Vital	or Att	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, streething building, etc. (Specify)	eet, factory, office	28	3f. Location (Si City or Town		Rural Route Number,
	spitel ours a neral t		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	accurred at the time	date and place, an	d due to the c	auco(s) and manner	a a stated
	To the Hospitel or Attending Physicien: The law within 24 burus after death, within 24 burus after death, To the Funeral Director; Atten this certificate has completely filled in by the funeral director, page 2.	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or invariant manner stated.	estigation, in my opini	ion, death occurred	at the time, d	ate and place, and d	ue to the cause(s)
	To T com	Σ	29b. Signature and title of certifier	29c. License no		2	9d. Date signed (Mo.	nth, Day, Year)
10	>		comme	D41	128		7/19/	105
(0)	E.G.		30. Name and address of person who completed cause of death (Item 23a) (Type, F	<i>'</i>	D1 + 7 7	100 C	0055	
	Sta	te	Charles Harrison M.D. 6001 Muncaster 31. Date filed (Month, Day, Year) 32 Registrar's Signature		KOCKVILLE	• MD 20	7822	
	Registra	ar	JUL 1 8 2005 Brew & Apr	w				

DHMH 17 Rev 1/2001

2005

FULLER

	W ===		1 - For State Registrar	State of	Maryland /		artmen rtificate			and M		giene	005	25005
П	Physici	an	Decedent's Name (First, Middle, L.								2. Date of Dea Month	ith Day	Year	9. Time of Death
	/Medi	cal	George Donald 4a. Facility Name (If not institution, gi		han)		45 00	.		15 11	July	27,	2005	2:30 P. M
	Examir	ier	21246 Leiters Mi		Del)		46. City,		Location o				ounty of Deat	
	Funeral			Sex 7	'. Age (In yrs. last i	birthday)	If Under	1 Year	If Under		8. Date of Birtl (Month, Day		Washing 9. Birti	hplace (State or Foreign untry)
	∞Director		218-24-1621	1 X 2MM 2□ F	75	Yrs.	Months	Days	Hours		Sept. 6			untry) nsylvania
	and		Usual Residence of Decedent 10a. State 10b. County		10c, City, To	wn or Lo	cation							10d. Inside City Limits
	Maryl -f sho	Į	Md. Wash	nington			Hager	stow	n					1 □ Yes 2 X No
	r 28a	Director	10e. Street and Number				10f. Zip					10g. Citize	n of What Co	untry?
	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-1 show «Stal Examenatinust be notified at	al D	21246 Leiters Mi	ill Rd.				2	1742				U.S.	A
	tems	Funeral	11. Marital Status	Armed Ford		13. V	Was Deced f Yes, spec	ent of His	panic Orig	gin? (Spec	cify Yes or No- lican, etc.)	14	. Race - Amei Black, White	
36	I', or I	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 If Yes, Give Year or Dat			1 ☐ Yes 2	No No	Specify:			S	рөсify:	White
9	72 hound	ted	15. Decedent's B	ducation		a. Deced	tent's Usua	I Occupat	ion			16b. Kind	of Business/I	ndustry
218	·	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1	4or 5+)	(Give life. L	kind of wor DO NOT us	k done du e retired)	ı <i>ring m</i> ost	of workin	g			,
21	T1 CD =		12			Ma	chini						Airc	raft
Maryland 21215-0036	be de la	Ве	17. Father's Name (First, Middle, Las George R. Feis						18. Mothe		(First, Middle, . .ian I.		- /	
ī	2 should be and Mental Is marked (aumatic ev	To	19a. Informant's Name/Relationship		19	9b. Mailin	a Address	(Street ar	nd Numbe		Route Number			in Code)
M	ロボトラ		Judith T. Feiser								Hagerst			
ore,	es 1 a of Hei fitem r othe		20a. Method of Disposition 1 □ Burial 2 🏋 Cremation 3 [Demousi from C	20b. Place	of Dispos		a of		Da	ate		tion - City or 1	
Ë	Pag ment ant: I		4 □ Donation 5 □ Other (Speci		Smith	sbur	g Cre	mato	777 L	July 2005	28,	Smi	thsbun	g,Md.
Baltimore,	permit. Pages 1 and Deportment of Healt Important: If item 2 any injury or other 2006s.		21. Signature of Funeral Service Lice	insee	M01414		. Name and L. Da				125 Iome Smi	525 B	radbur	y Ave.
			23a. Part1 Enter the disease, or conshock, or heart failure. List only	plications that can	used the death. Do			of dying,	such as o	cardiac or				Approximate Interval Between
	Physician	ì	Immediate Cause (Final disease or condition resulting in death)	a C	your o	of str	·ch.re	1	sumo	sha	Ohises	ve		Onset and Death
	/Medical Examiner		Tosaiting in doate)	Due to (o	as a consequence	e of):	1.6m	لام لام		U				un burn.
	4	e	Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Utile to (or	r as a consequence	e of):	3			W =				Display.
de	cate be executed bhysician and the burial-transit.	Examiner	mai milated events	c		(
8760, 🕏	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (o	r as a consequence	e of):								
	icate b physic s the b	Physiclan/Medical		d			-	_						
9 x	that the death certific ed by the attending p detached for use as	/Me	IF FEMALE:	23c. If yes, outco	ome of pregnancy							00	L Data of data	
. Box	death e atter d for u	iclar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birt 4☐Pregnar	h 2 Fetal deat nt at time of death		Ectopic pre Other (spe					230	I. Date of delive Month	Day Year
P.O.	at the by the tache	hys	9 🗌 Unknown	9□ Unknow										
S,	Se Le	by	Part II. Other significant conditions	contributing to dea	th but not resulting	in the un	derlying ca	use given	in Part I.					the cause of death?
Division of Vital Record	w require been sig	Completed						· 			1 476	s 2 🗆 N	√o 3 □ Pro	bably 4 Unknown
Rec	The law ate has l	mp									24a. Was a autops perforn	y .	24b. Were autoprior to condeath?	opsy findings available empletion of cause of
ē	in: The lift of th	e Co	25. Was case referre to medical								1 ☐ Yes 2	No		2 No
<u> </u>	Phyalcian: The la	0 8	examiner? 1 Yes 2 No	Hospital:	patient 2 ER/O	utpatient	3 🗆 DOA				Check only on Beside		Other (Special	6.1
0	Attending Physician: r death. ector: After this certifice by the funeral director.	T iu	27. Man of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of		Time of Injury		c. Injury a	ıt it	28	d. Describe ho	w injury o	ccurred	19)
Sio	r Attending Ph ar death. rector: After th by the funeral	catic	2 Accident investigatio	n		,ury	М		s 2 🗆 N	io				
Σ		Certification:	3 Suicide 6 Could not be determined	286. Place o	f Injury - At home, f , etc. <i>(Specify)</i>	farm, stre	et, factory,	office		28	If. Location (St. City or Town	reet and N I, State)	lumber or Rur	al Route Number,
_	To the Hospital or within 24' hours affe To the Funeral Dir completely filled in	20	29a. Certifier 1 Cartifying Pt	vsician: To the h	est of my knowledg	ie. death	Occurred -	t the time	date of	I place a	d due to the	wec/=) -	d mac-a: -:	tated
	Ne Hos 1 24'h Ne Fur Metely	edical	(Check only 2 Madical Example)	minar: On the bas and manne	is of examination a	nd/or invi	estigation, i	in my opir	ion, death	n occurred	at the time, da	ate and pla	d manner as s ace, and due t	o the cause(s)
	To the h within 24 To the f complete	Me	29b. Signature and title of certifier				29c.	License r	number		25		igned (Month.	
	./		▶ /∑					04	172	88		0.	7, 28,	2005
	5		30. Name and address of person who								1742			
	Sta		Shaheen Iqbal M.D. 31. Date filed (Month, Day, Year)	44.70				ers c	.W11 ₽1VI	u. 2.	1146			
	Registra	-00	AUG 0 1 2	005	we to	do	W							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month Day 0800 A^M July 18, 2005 VIRGINIA BRUFFY GIBBS 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Wicomico Coastal Hospice at the Lake 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) Months 1□M 2√F 84 Aug. 29, 1920 Virginia 071 12 9053 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 21801 U.S.A. Acre Drive Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 2 **X**No 1 Yes 2 No Specify: Specify: White

death with the Maryland 27 is marked other than "naturaf", or Items 23a or 28a-1 show traumatic avent. The Medical Examinat must be notified at Director Maryland 10e. Street and Number 1103 South Stream Funeral e filed within 72 hours after all Hygiene. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17 Father's Name (First, Middle, Last) Be 2 should be fi and Mental H is marked of ဥ Elmer Lee Bruffy 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or othar traun Gail Gibbs Carozza 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 21. Signatule of Fundral Service Liensee Immediate Cause (Final disease or condition resulting in death) Pnysician Renal Failure /Medical **Examiner**

1 - For State Registrar

10a State

Physician

Examiner

Funeral

Director

/Medical

4456 Sturbridge Dr. Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Evergreen Cemetery 7/21/05 Berlin, Maryland 22. Name and Address of Facility

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Apartment Owner/Operator

18. Mother's Name (First, Middle, Maiden Sumame)

Margaret Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

108 William St. The Burbage Funeral Home Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one was an each line.

Approximate Interval Between Onset and Death 1 Year

Year

Sequentially list conditions, if any, leading to immediate the sequence of the

Examiner

Physician/Medical

þ

Completed

Be

2

Certification:

Medical

IF FEMALE

attending physician and for usa as the burial-transit certificate ba executed

the

Box 68760

P.O.

Division of Vital Records.

Hospital or Attending Physician:

after death.

within 2

Due to (or as a consequence of):
Nephrosclerosis

Due to (or as a consequence of):

Due to (or as a consequence of):

23b. Was decedent pregnant in the past 12 months?

1 Yes No
9 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death

3 Ectopic pregnancy 4□Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Day

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2√2 No

16b. Kind of Business/Industry

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner?

1 ☐ Yes 2 🗙 No 27. Manner of Death

29b. Signature and title of certifity

1 Natural 2 Accident 6 Could not be 3 🗌 Suicide determined 4 Homicide

28a. Date of Injury (Month, Day Year) 5 Pending investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No M

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

24a. Was an autopsy performed 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29c. License number

D26278 7-18-05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Cowall, MD Coastal Hospice P.O. Box 1733 Salisbury, MD 21802

State Registrar

ET/2

L 1 8 2005

egistrar's Signature

		1		State of Maryland / Depa		-	ne
	Physicia /Medica Examine	n al	1. Decedent's Name (First, Middle, Last) Alice Cecelia G A. Facility Name (If not institution, give s		4b. City, Town, or Location of Deat	July 1	Day Year 3. Time of Death 15 2005 2:31 P M 4c. County of Death
	uneral rector	1	5 Sandy Circle 5 Social Security Number 036-09-1530 Usual Residence of Decedent	M 2XXF 7. Age (In yrs. last birthday) 92 Yrs.	Ocean Pines If Under 1 Year If Under 24 Hrs Months Days Hours Min	8. Date of Birth	Worcester 9. Birthplace (State or Foreign Country) Rhode Island
the Maryland	28a-f ehow		10a. State 10b. County MD Worcester	10c. City, Town or Lo Ocean Pir		10g.	10d. Inside City Limits 1 ☐ Yes 2C(No Citizen of What Country?
5-0036 72 hours atter death with the Maryland	item 27 Is marked other then "neturel", or Items 23a or 28a-f ehow other treumetic event, I're Modical Examiner must ke notified at	Completed by Funeral Director	5 Sandy Circle	1 □Yes 2 TXNo	21811 Was Decedent of Hispanic Origin? (\(\frac{1}{2} \) Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:	Specify Yes or No- to Rican, etc.)	A 14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036 to 2 should be tiled within 72 hours alt tilh and Mental Hygiene.	er then "neturel" , the Musical Ex	Completed b	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation 162 Decer		U.	S. Government
ryland 2 hould be tiled of Mental Hygie	narked oth	To Be (17. Father's Name (First, Middle, Last) Harry Leeti 19a. Informant's Name/Relationship (Ty)	na Print) 19h Mailir		me (First, Middle, Maid heresa Pic Jural Route Number, Ci	kett
Baltimore, Ma permit. Pages 1 and 2. Department of Health a	Importent: If item 27 Is eny injury or other tret <u>once.</u>		Frank Gilmore (Son 20a. Method of Disposition Burial XX Cremation 3 R	emoval from State 20b. Place of Dispo cemetery, cref Cape Hen	Summit Ct., N.E., sistion (Name of matory or other place) lopen Crem. 7-1 Z. Name and Address of Facility 108 William St.,	6-05 Fr he Burbage	ankford, DE Funeral Home
/M/ Exa	sician and sician and sician and sician and sicial straight transit	Ilcal Examiner	2.4. Part1. Enter he disease, or combine shock, or hear ailure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or highly that initiated events resulting in death) Last	ations that cause due deam. Do not enter e cause on each ine. The to (or as a consequence of): The to (or as a consequence of): Due to (or as a consequence of):	ter the mode of dying, such as cardia	ac or respiratory arrest,	Approximate Interval Between Onset and Death 46 month 4-6 month
I Records, P.O. Box 68760, The law requires that the death certiticate be executed	by the attending physicached for use as the t	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 XNo 9 Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ords, P.	been signed b should be deta	by	Part II. Other significant conditions con	tributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death? 2 No 3 Probably 4 Unknown
al Kecon: The law re	certificate has be ector, page 2 sh	Completed				24a. Was an autopsy performed 1 Yes 2	
Division of Vital Records, or Attending Physician: The law requires taffer death.	fter this meral dir	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 X No 27. Manner of Death 1 Natural 5 Pending investigation	ospital: 1 Inpatient 2 ER/Outpatie	nt 3 DOA Other: 4 Nursing	Home 5X Residence 28d. Describe how	e 6 ☐ Other (Specify) injury occurred
Divisio Mitel or Attendi	rel Director	Medical Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)		City or Town, S	
To the Hosp	To the Funeral Director: A completely filled in by the to	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier	sician: To the best of my knowledge, deat ner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place investigation, in my opinion, death occurred. 29c. License number	curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s) Date signed (Month, Day, Year)
, H	.10	ite	30. Name and address of person who a	mpleted cause of death (Item 23a) Type.	(3007 Co	H 25te	215 Quan Cit

			1 - For Stete Registrat/AMEND#23@	24ash					artment of H Hificate of I		nd Meni	-			
	9		Decedent's Name (First, Min		2//2	27/03	,010,110	90,	imodio or i	Doain	2. D	ate of Deat	eg. No 2 ()	05	2 Time of Death O
	Physici		Ronald Berna:	rd Go	yette						N.	fonth	Day	Year	10:04 a M
\	/Medic Examin		4a. Facility Name (If not institu	tion, give s	treet and nun	nber)			4b. City, Town, or	r Location of D		11y 12		y of Death	10.04
			Holy Cross He	osnit.	al				Silver	Spring	~				
	Funeral		5. Social Security Number	6. Sex		7. Age (In yrs. last birt	hday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. D	ate of Birth		ntgon 9. Birthp Cour	lace (State or Foreign
L,	Director		014-38-2127	114	M 2□F		57	Yrs.	William Days	Tiours		v. 12			sachusetts
	and w		Usual Residence of Decedent 10a. State 10b. Cou	ntv		1	0c. City, Town	orlo	cation						Od Incido City Limite
	danyl f sho	ō												'	0d. Inside City Limits 1 ☐ Yes 23 No
	28a	Director	10e. Street and Number	tgome	er y		5110	er	Spring 10f. Zip Code			11	0g. Citizen of	What Cour	
	3a or	ā	10320 Науwoo	d Dri	ve				20902					USA	iu y :
	death ms 2	Funeral	11. Marital Status		12. Was Dece		er in U.S.	13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin	n? (Specify)	res or No-		ce - Americ	an Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or flems 23a or 28a-f show any injury. Or proper traumatic event, the Medical Examinative Indiffed ut once.	by	1 ☐ Never Married 2 🔀 M 3 ☐ Widowed 4 ☐ Divord	i	Amed For 1 ☐ Yes If Yes, Give Year or Da	2 X No e			Yes, specify Cuba	in, Mexican, P Specify:	Puerto Rican	ı, etc.)		ick, White, fy: Whit	
5-0	72 h	Completed	15. Deced (Specify only hig	ent's Educ	cation completed)		16a.	Deced	lent's Usual Occupa	ation	f working		16b. Kind of E	Business/Ind	dustry
121	vithin ne. hen.	mpi	Elementary/Secondary (0-12		College (1-	-4or 5+)		life. L	OO NOT use retired	0	, working				
N N	iled v dygie ihar t nt, ih		17. Father's Name (First, Midd	(n. / ant)	5+			Bus	siness Ma		A.1 (FF)		Private		ool
and	ad be f	Be C	Alcid E. Goy										Maiden Sumai	me)	
Maryland	should id Me mark matic	2	19a. Informant's Name/Relation		ne Print)		10h	Mailin	g Address (Street a				ovanni		2 11
Z	nd 2 s lith ar 27 ls r trau		Mary J. Goyet						20 Haywoo						
re,	t Hearlitam		20a. Method of Disposition				20b. Place of	Dispos	sition (Name of	T	Date	2	20c. Location		
Ë	Page int: #		1 X Burial 2 ☐ Crematic 1 4 ☐ Donation 5 ☐ Other		emoval from S	State			natory or other place ven Cemeter	1	July 2005	18 Bj	ilver S	Spring	, Maryland
Baltimore,	permit. Departm Imports any inju		21. Signature of Funeral Servi	Lice Lice As	nses			Fr 50	Name and Address ancis J.	s of Facility.	ns Fur				MD 20901
			23a. Part1. Enter the disease,	or complic	cations the ca	aused the	e death. Do n	ot ente	er the mode of dying	g, such as car	rdiac or resp	piratory arre	est,	JI III 9 ,	Approximate
	Physician ¹		Immediate Cause (Final	ist only on	e cause on ea	ach line.									Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	a.			Athero		erosis						
	Examiner		Cognostiathy list conditions	, h	Acute	Мус	cardia	1 1	nfarction	n					
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	"	Due to (c	or as a c	onsequence o	1):							
	tificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.					lypertropl	hy					
60,	be ex	E	Todaking in dodkin Zast		Due to (d	or as a c	onsequence o	f):						П	
68760,	physic the l	ledical		d.				_	7						
ox 6	certif nding ise as	/Me	IF FEMALE:	23	Bc. If yes, outo	come of	pregnancy						20.1.0		
о. В	The law requires that the death certificate be executed tee has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			rth 2 [ant at tim	Fetal death		Ectopic pregnancy Other (specify)				1	ite of delive onth	ry Day Year
٥.	s that ned b	by Ph	Part II. Other significant cond	itions conf	tributing to de	ath but n	ot resulting in	the un	derlying cause give	n in Part I.	2	3e. Did tob	acco use con	tribute to th	e cause of death?
Records,	w require been sig should bo	q pa										1 🗌 Ye	s 2 🖾 No	3 Prob	ably 4 Chknown
000	s bee	Completed									2	4a. Was an	1 24b.	Were autor	osy findings available
	The lav	mo						_			_	autopsy perform	/ led?	prior to con death?	npletion of cause of
Vital		Bec	25. Was case referred to medi	cal						26. Place of				1 🔀 Yes	2 100
	Physic this ce al dire	10	examiner? 1 ☐ Yes 2 No	Ho	ospital: 1□In	patient	2 X ER/Out	patient	3□ DOA Othe				nce 6 Oth	ner (Specify)
ב	Attanding Physician: r death. actor: After this certifici		27. Manner of Death 1 XNatural 5 ☐ Pen	dina	28a. Date of (Month)	f Injury n, Day Ye	ear) 28b. Ti	me of jury	28c. Injury Work				w injury occur		
<u> </u>	tandi death. tor: A the fu	catl		stigation					M 1 🗆 Y	res 2 □ No					
Division of	Dir	Certification:		mined	28e. Place of building	of Injury g, etc. (- At home, far Specify)	m, stre	et, factory, office		28f. Lo	ocation (Str ity or Town,	eet and Numb State)	er or Rural	Route Number,
	To the Hospital within 24 hours a To tha Funaral I completely filled	edical	29a. Certifier 1. Certifier (Check only one) 1. Medic	ying Physi al Examin	er: On the land	SIS OT 0X	amination amp	death /or inv	occurred at the tim estigation, in my op	e, date and pl sinion, death o	place, and du occurred at t	ie to the car he time, da	use(s) and ma te and place,	anner as sta and due to	ated. the cause(s)
	To the To tha Complet	Σ	29b. Signature and title of certi	fier	1 6.	7 (Juli	w	29c. License	number	924	29	d. Date signe	d (Month, E	Day, Year)
	V		30. Name and address of personal Lawrence A.							2024 0	047	C	n a - 15	200=	0
	Sta	e	31. Date filed (Month, Day, Yea						st Glen F	wau, s	errver	spri	ng, MD	2091	U
P. C.	Registr		JUL 18		tent	. ري	Signature	134						133	

UNK NJM	05-04808		State of Maryland / Department of Health and N Certificate of Death		ne ₂ nn5	25009
	8 - 1 - 1	54.	1. Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death
	Physicia		Steven Thomas Gordon	July	16 2005	1220 M
	/Medic		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	
			Route 225 & Ripley Road Indian Head		Charles	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 1 \(\text{M} \) M 2 \(\text{F} \) 7. Age (In yrs. last birthday) Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birth	place (State or Foreign ntry)
	Director		217-78-7249 38 Yrs. Usual Residence of Decedent	Aug. 12,	1966 Virg	inia
	land		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mary I-f ⊕h	tor	Maryland Charles White Plains			1 Tes Anno
	th the	lrec	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Cou	ntry?
	17215-0036 within 72 hours atter death with the Maryland ene. than "natural", or iteme 23a or 28a-1 ehow the Moulcal Examinar must be notified at	Funeral Director	7701 Chesterfield Court 20695		USA	
	teme	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. 14 May Decedent of Hispanic Origin?) (Sp. 15 May Decedent of Hispanic Origin?)	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
	36 satte	by F	1 ☐ Never Married 2 ፟፟ Married 1 ☐ Yes 2 Î No If Yes, Give 1 ☐ Yes 2 Î No Specify: 3 ☐ Wildowed 4 ☐ Divorced Year or Dates:		Specify:	White
	turai		15. Decedent's Education 16a. Decedent's Usual Occupation	168	. Kind of Business/tr	ndustry
	215	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of work life. DO NOT use retired)	king		_
	21.20 will	Completed	12 2 Director MRI Facility		Medio	ca I
	nd be file d oth	Be	17.1 dillo o Mario (1. mo), mario, mario	ne (First, Middle, Mai ette Lee J		
	Vanid Menid	2	Date William Got Got			a Coda)
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or iteme 23a or 28a-1 ehow eny injury or other treumatic event. The Musical Examination at policed at		Tammy Irene Gordon - Wife 7701 Chesterfield Ct.,		•	
	e, l 1 and Health m 27 ther t	1	20a Method of Disposition 20b. Place of Disposition (Name of		. Location - City or T	
	Ages nt of 1		1kD Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Trinity Memorial Gdns 7-21	-05 Na	ldorf, MD	
	Itin			wa	ומטוו, ווט	
	Dep impo		Huntt Funeral Home	lorf, MD 2	0604-0156	
	9 5		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition August 1975)			Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):			
	Examiner		Sequentially list conditions			
	D #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
	60, be executed sician and burial-transit		Dad to (of as a consequence on).			
	Division of Vital Records, P.O. Box 68760, To the Hospitei or Attanding Physician: The law requires that the death certificate be exwitin 24 hours attended the tast of the Funerel Director. Atten this certificate has been signed by the attending physician completely lilled in by the tuneral director, page 2 should be detached for use as the buria	by Physician/Medical	d.			
	certif	Z Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delin	very
	P.O. BOX hat the death cert d by the attendin letached for use	cla	in the past 12 months? 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
	oy the	hys	9 ☐ Unknown			
	COTGS, P	y P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		co use contribute to	
	ould b			1 🗆 Yes	2 ₹No 3 Pro	bably 4 Unknown
	Division of Vital Records, i or Attanding Physician: The law requires t atter death. Director: Atten this certilicate has been signe in by the tuneral director, page 2 should be a	Completed		24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
	The The page	Son		res 2□		2 🗆 No
	/ita	Be	examiner?	ath (Check only one)		~
	of \ Physical this cal	2		lome 5 Residence 28d. Describe how		ify) Scene
	Jing F	on	1 Natural 5 Pending (Month, Day Year) Injury Work?	271		CON HAT GUNED
	isic stand death ctor: y the	licat	29Accident	28f. Location (Street	at and Number or Ru	
	Div A atter atter Dire	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	RT 225 CHIPL		WHERE MO
	spite nours nerel	a C	29a. Certifier 1 ertifying Physicien: To the best of my knowledge, eath occurred at the time, date and place	, and due to the caus	se(s) and manner as	stated.
	n 24 i	edical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence) and manner stated.	irred at the time, date	and place, and due	to the cause(s)
	To the within To the comp	Σ	29b. Signature and title of certifier 29c. License number	29d	. Date signed (Month	
	•		Mayne The Gall MM OCME		July, 17	, 2005
	10 -		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
	DDIZ		MANUALLA DE CORE, Baltimore, MD			
	St Regist	ate rar	31. Date filed (Month, Day, Year) JUL 1 9 2005 32. Restrar's Signature			
	A STATE OF					

				of Maryland / Depa		ealth and		9	•
			State Registrar 1. Decedent's Name (First, Middle, Last)	Ce	rtificate of L	Jeath	2. Date of De	Reg. No.2	5 25010
	Physici		Catherine M. Gorschbo	+h			Month	Day Yes	5:30 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and no		4b. City, Town, or	Location of De		4c. County of D	
		•	Casey House		Rockvill			Montgom	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2X F	7. Age (In yrs. last birthday)	Months Days	If Under 24 H Hours Mi		th ly, Year) 1928 Ma	Birthplace (State or Foreign Country) ryland
	ow II		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary B-1 sh	tor	Maryland Montgomery	Silver Sp	ring				1 ☐ Yes 2 ☐XNo
	or 28	Dire	10e. Street and Number		10f. Zip Code			10g. Citizen of What	Country?
	s 23a	rai	513 Highgate Terrace	cedent Ever in U.S. 13.	20904 Was Decedent of Hi	ispania Origin?	/Specify Vec or No	USA	merican Indian,
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show appringing to other traumatic avant, the Madical Exeminer must be notified at ance.	Completed by Funeral Director	Armed F	orces? 2 XNo ive	If Yes, specify Cuba	Specify:	erto Rican, etc.)	Black, W	hite
21215-0036	72 hou	eted	15. Decedent's Education (Specify only highest grade completed	16a. Dece	dent's Usual Occupa	ation during most of w	vorkina	16b. Kind of Busine	
2	vithin ne.	mple	Elementary/Secondary (0-12) College	(1-4or 5+)	kind of work done of DO NOT use retired)	· · · · · · · · · · · · · · · · · · ·		T . T 1.1
22	filed w Hygie thar t		17. Father's Name (First, Middle, Last)	Віос	hemist	18. Mother's N	lame (First, Middle	National , Maiden Sumame)	Inst. Health
/lan	Mental Mental arked o	To Be	Joseph Metzger				r Reinig	,	
Maryland	id 2 sho lth and 27 is ma trauma		19a. Informant's Name/Relationship (Type, Print) Frederick F. Gorschboth		•			er, City or Town, Stat Spring, MD	
Baltimore,	les 1 an of Heal of itam? or other		20a. Method of Disposition 1 ☐ Burial 2 ☼Cremation 3 ☐ Removal from	20b. Place of Dispo	osition (Name of matory or other plac		uly 16,	20c. Location - City	
Ě	. Pag tment tant:		*4 ☐ Donation 5 ☐ Other (Specify)	W. Arund	el Cremat	-	005	Odenton,	
Ba	Depar Import any ir		21. Signature of Funeral Service Licensee Bevery L. Hall	M01251 B	everly L.	Heckro	tte, P.A.		Box 784 11e.MD 21029
	Physician /Medical Examiner		Due to	nced Gastric (or as a consequence of):		9, 543,740 5415	as or roophatory a		Interval Batween Onset and Death
68760,	eath certificate be executed attending physician and for use as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c	(or as a consequence of):					
.O. Box (9 0 9	Physician/Med	in the past 12 months?	nant at time of death 5 [□Ectopic pregnancy □ Other (specify)			23d. Date of Month	delivery Day Year
s, D	law requires that the der as been signed by the a 2 should be detached f	by	Part II. Other significant conditions contributing to	death but not resulting in the u	underlying cause give	en in Part I.			e to the cause of death? Probably 4 Unknown
al Record	The ate h	Completed					24a. Was auto perfo 1 Yes		
Vital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?		Othe		eath (Check only o		1
of	Phys r this aral di	.: To	27. Manner of Death 28a. Date	Inpatient 2 ER/Outpatien of Injury 28b. Time of				dence 6X_Other (S how injury occurred	Specify) hospice
ion	Attanding Property of the funeral type of the funeral type funeral typ	atior	1 X Natural 5 ☐ Pending (Mo 2 ☐ Accident investigation	nth, Day Year) Injury		k? Yes 2 □ No	1		
Division	al or Attandi safter death I Diractor: A d in by the fi	Certification;		e of Injury - At home, farm, st ding, etc. (Specify)	reet, factory, office		28f. Location (City or To		Rural Route Number,
	To tha Hospital or Attanc within 24 hours after death To tha Funaral Diractor: completely filled in by the	edical C	29a. Certifier (Check only one) Certifying Physician: To the 2 Medical Examiner: On the and ma	e best of my knowledge, deal basis of examination and/or in nner stated.	th occurred at the time	ne, date and pla pinion, death oc	ice, and due to the courred at the time,	cause(s) and manner date and place, and	as stated. due to the cause(s)
	To tha within 2 To tha comple	Me	29b. Signature and Hilla bit partition		29c. License			29d. Date signed (M	onth, Day, Year)
1.6			Charles 11/C		- 04	121	8	7/15/	05
12	EG.		30. Name and address of person who completed car Charles Harrison $M_\bullet D_\bullet$ 6	001 Muncaster	Mill Rd.	Rockvi	11e, MD 2	20855	
	Sta Registi		31. Date filed (Month, Day, Year) JUL 1 8 2005						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registratemend item #21 per fh 8846 8/46/05 TH Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Jul 26, 2005 **Physician** Gilchrist Jeanette /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Cumberland 646 Washington Street If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days (Month, Day, Feb 17, PÄ 1 ☐ M 2 ☐ F 1920 Yrs. 85 Director 265-18-5277 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Iteme 23a or 28e-1 show any highry or other treumatic event, it's Madical Examinar must be notified at once. 28e-1 show 1 ☐Yes 2 ☐ No Cumberland MD Allegany Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21502 646 Washington Street Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jeanette Lynn Whelan Joseph Whelan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD 21502 Cumberland 110 Washington Street attorney Steve Hidey 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 7/27/2005 MD Scarpelli Funeral Home, PA Cresaptown ³ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. per DVR. JAMES F. SCARPELLI MO0506 108 Virginia Avenue; Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3425 7ve Physician /Medical sequence of): Due to (or as a co **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ξō in the past 12 months? 1 ☐ Yes 2 ▼No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 2 No Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performe 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 No To the Hospitel or Attending Physician: 26. Place of Death Check onl one director, Be 25. Was case referred to medical examiner? Other: 4 Nursing Home Hospital: 5 esidence 2 1 No 1 Inpatient 2 ER/Outpatient 3□ DOA 6 ☐ Other (Specify) 2 1 🗌 Yes this 27. Mann Death 28a. Date of Injury (Month, Day Director: After that in by the funeral 28b. Time of 28c 28d. Describe how injury occurred Injury at Work? Certification: 5 Pending 1 🗆 Yes investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide within 24 hours a To the Funerel I 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29th Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

Gary Wagoner M.D.

925 Bishop Walsh Drive Cumberland MD 21502

			1 - For State Registrar	State of Maryla		artment of I			iene •9. N2 0 0 5	25012
	Physici	an	Decedent's Name (First, Middle, La. TAMEC	•	II A DDY			2. Date of Dea Month	Day Year	3. Time of Death
	/Media	al	JAMES 4a. Facility Name (If not institution, giv	D.	HARDY		or Location of De	JULY	12 2005 4c. County of Dea	
	Examir	er	WASHINGTON ADVEN			,	SPRING	201	MONTGOME	
	Funeral Director		424-20-3031	ex 7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days			1929 9. Bi r 28 ALA	rthplace (State or Foreign ountry) ABAMA
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	ocation				10d. Inside City Limits
	ith the Marylar or 28a-f show e notified at	tor	MD PRINCE	GEORGE'S G	LENDALE					1 XYes 2 ☐ No
	th with the 23a or 28s	al Director	10e. Street and Number 11408 STRAWBERR	Y GLENN LANE		10f. Zip Code 20769		1	0g. Citizen of What C	ountry?
036	or items	by Funeral	11. Marital Status 1 Never Married 2 Married 3 WWidowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2∑ No If Yes, Give Year or Dates:		Was Decedent of lift Yes, specify Cub		(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh Specify:	
21215-0036	filed within 72 hours Hygiene. other than "natural", ont, tre Mudical Exe	Completed	15. Decedent's E. (Specify only highest gra Elementary/Secondary (0-12) 7 th	ducation ide completed) College (1-4or 5+)	16a. Dece (Give life. LABC	dent's Usual Occu kind of work done DO NOT use retire ORER	pation during most of wed)	vorking	16b. Kind of Business PRIVATE	Andustry
Maryland 2	should be filed within and Mental Hygiene. I marked other than urnatic event, II a Mi	To Be Co	17. Father's Name (First, Middle, Last, RUFUS HARDY					ame (First, Middle, LUE COI	Maiden Sumame) LEMAN	
Mar	12 sho h and 7 is m		19a. Informant's Name/Relationship (r, City or Town, State,	
	Health tem 27 other tr		WANDA HARDY GARNE 20a. Method of Disposition			osition (Name of matory or other pla		-	20c. Location - City o	RYLAND 20769 r Town, State
E O	Pages nent of nt: If it		1 ☐ Burial 2 🛣 Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif	TUGUIOVALITORI STATE		E CREMAT	i i	5/05	RIVERDALE,	MARYLAN D
Baltimore,	permit. Pages 1 al Department of Hea Important: If Item any injury or othe once.		21. Signature of Funeral Service Licer	ha (2. Name and Address	ess of Facility	J. B. JEN	KINS FUNER	
	Physician /Medical		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Pre	VW	ter the mode of dy	ing, such as card	ac or respiratory arr	est,	Approximate Interval Between Onset and Death
þ	Examiner	- E		b. Due to (or as a conse	mi	rtest	red !	leed	2	
8760,	ate be executed hysician and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conse	equence of):					
687	ficate physics the	edlc	•	d						
.O. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregi 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	☐Ectopic pregnand ☐ Other (specify)	Ç y		23d. Date of de Month	Blivery Day Year
9	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	inderlying cause gr	ven in Part I.		bacco use contribute t es 2 □ No 3 □ F	to the cause of death?
Records,	The ate his page	Completed						24a. Was a autops perform	in 24b. Were a prior to death?	autopsy findings available completion of cause of
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital		-		eath (Check only or	18)	
of		٠ <u>.</u>	1 ☐ Yes 2 No 27. Manner of Death		ER/Outpatie	IL SLI DOA			ence 6 Other (Spoow injury occurred	ecify)
lon	Attending Phi r death. ector: After thi by the funeral o	tlon	1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)	Injury	Wo	ork?]Yes 2 ☐ No	20d. Describe in	ow injury occurred	
Division	≥ He e	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st	reet, factory, office		28f. Location (S City or Town	treet and Number or F n, State)	lural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Exal	ysician: To the best of my kr niner: On the basis of examin	nowledge, dear nation and/or in	h occurred at the t	ime, date and pla opinion, death oc	ce, and due to the c curred at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
	omple	Med	one) 29b. Signature and titte of certifier	and manner stated.		29c, Licen	se number		29d. Date signed (Mor	th, Day, Year)
	P > P 0		A			-101	1807	7	7/13	105
	Jn 6		30. Name and address of person who	completed cause of death (Ite	эт 23а) (Туре,	Print)	examp	gr 2:	Z We	oh.
	- 04	10	31. Date filed (Month, Day, Year)	A2. Registrar's Sign	nature -	AL 110 K	werd	ale m	12 2073	57,
	Sta Registr		111 1 0 200	Ke D. A	draw	le				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. NO 1 Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2005 July 10:49A M Edward Manuel Hardesty /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 Union Hospital of Cecil County E1kton Hours Min. 8. Date of Birth (Month, Day, Year)
Mar. 14, 1941 If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F West Virginia 64 Director 219 26 4819 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits other traumatic event, the Mudical Exeminer must be notified at 1 Yes 2 □ No Director Maryland | Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 28 Roosevelt Avenue 21901 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married Married Specify: white 1 Yes 2 No 3 Widowed 4 Divorced natural Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed withln nent of Health and Mental Hygiene. int: if Item 27 is marked other then Elementary/Secondary (0-12) College (1-4or 5+) 3 Owner/Operator Excavating 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Walter Hardesty Carol Orndoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if Item 27 is any Injury or other trau once. Mary Hardesty/Wife 28 Roosevelt Avenue, North East, Maryland 21901 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date XBurial 2 ☐ Cremation July 19, 3 Removal from State Union Cemetery * 4 ☐ Donation 5 ☐ Other (Specify 2005 Elkton, Maryland 21. Signature of Ryneral Service License 22. Name and Address of Facility Crouch Funeral Home M00510 127 South Main Street, North East, Maryland 21901 Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** mydeeld ace 129 /Medical Due to (or as a consequence 4) Examiner COPD Exacelection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law raquires that the death certificate be executed burial-transit Diale resulting in death) Last Due to (or as a consequence of): aitherisa lerosic Be Completed by Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month 4 Pregnant at time of death 5 Other (specify) been signed by tha e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 No 2 No 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 2 ☐ Accident 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funaral Director: A investigation filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DO 48 23 coor Wa MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JU1 HSU, MD CH111 223 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JUL 1 9 2005

Maryland 21215-0036

Baltimore,

P.O. Box 68760

Division of Vital Records,

		-	For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H			giene	
	Physicia /Medic	an	Decedent's Name (First, Middle, Last Ouay Adna Johnson					2. Date of Dea Month	ath ZU (Day 25 ZO	Year 9:45 AM
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Dea	th /	4c. County	
			Washington County 5. Social Security Number 6. Se		e (In yrs. last birthday)	Hagerst	LOWN If Under 24 Hrs	8. Date of Birt		Ington
П	Funeral Director			Ž M 2□F	81 Yrs.	Months Days	Hours Min		y, Year)	Birthplace (State or Foreign Country) MD
	pu »		Usual Residence of Decedent 10a. State 10b. County	<u> </u>	10c. City, Town or Lo	ocation			,	10d. Inside City Limits
	Maryla f eho	ō	PA Franklin		Mercersbu					1 ☐ Yes 2 ☐ No
	r 28a-	Director	10e. Street and Number		TICTOCTODE	10f. Zip Code			10g. Citizen of W	Vhat Country?
	23e o 23e o ust be		13591 Little Co	ve Road		17236			USA	
	er dea	Funeral	11. Marital Status	12. Was Decedent F Armed Forces?	Ever in U.S. 13.1	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (In, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	- 14. Race Blac	e - American Indian, k, White, etc.
39	irs after	Ď	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 □XYes 2 □ N If Yes, Give Year or Dates:	10	1□Yes 2X No	Specify:		Specify	· White
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene importents: If item 27 is marked other than "natural", or Items 23e or 28e-f ehow amply injury or other treumatic event, the Madical Examination and once.	Completed	15. Decedent's Edi (Specify only highest grad		16a. Dece	dent's Usual Occupa	ation during most of we	orkina	16b. Kind of Bu	
2	vithin ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5	+) life.	DO NOT use retired	0		0 0.	
	Hygie Hygie other t	CO	17. Father's Name (First, Middle, Last)		Heavy	Equipment		.or me (First, Middle,		overnment
an	should be nd Mental marked o	To Be	Richard Johnson				Goldi	e Younke	r	
Maryland	2 shou and M is ma		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (Street a				State, Zip Code)
ô O	l and lealth		LaRue S. Johnson/W	ife		Little (d Mercer		PA 17236 City or Town, State
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		1 XBurial 2 ☐ Cremation 3 ☐		20b. Place of Dispo cemetery, crer		ł.			provensky skow.
Ħ	artme orten injury		4 □ Donation □ Other (Specify) 21 Signature of Fyneral Service Lice.	1 N		ve Method 2. Name and Addres			Mercersb est Main	
ä	Depar Impo any ir		1 Luch	30A	we G	rove Fune	ral Home			D 21750-0368
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory ar	rrest.	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a HATTER	(OSCHE)	OTIC (A	MOUNT	48CUCA	_ ()(SO)	HE YEAR
	/Medical Examiner		Testing in death)	Que to (or as	a consequence of):	11/1/16				,
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):	ectivity		·		
V	cuted nd rransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c						-4
8760,	sate be executed obysician and the burial-transit		resulting in death) Last	Due to (or as	a consequence of):					
387	death certificate be executed e attending physician and nd for use as the burial-transit	Physician/Medical	•	d						
Вох 6	death certifica attending ph d for use as the	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		76			23d. Date	e of delivery
		sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1∐Live birth 4∏Pregnant at 9☐ Unknown		∃Ectopic pregnancy ∃ Other (s <i>pecify</i>)			Mor	nth Day Year
P.0.	by ac	Phys	9 Unknown		A and an alling in the	- 4- 4- 1	an in Oant I	22a Did t	obassa uso sont	ribute to the cause of death?
		۾	Part II. Other significant conditions of	MAr) SCAST	nderlying cause give	en in Pan I.	1 1		3 ☐ Probably 4 ☐ Unknown
COL	requ	letec	i ZMOLLI (SMA	- Hun	CHITTAN.	11.		24a. Was	an 24b. V	Were autopsy findings available
Re	0 0	Completed	DU FALLUCIALIA	Co Co	SOCIC	4 0		autor	osy ormed?	orior to completion of cause of death?
ital	icien: Th certificate rector, pag	0	25. Was case referred to medical	1170- 36	1/313		26. Place of De	eath (Check only o		163 20110
) \		To B	1 Yes 2 Yo	Hospital: 1 Patie			4 Nuising	Home 5 ☐ Resid		
on c		lon:	27. Manner of Death 1 ☐ Hatural 5 ☐ Pending	28a. Date of Inju (Month, Day	ry y Year) 28b. Time o Injury	Worl	yat k? Yes 2 ∐ No	28d. Describe	how injury occurr	ed
Division of Vital Records,	l or Attending after death. Director: After In by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At home, farm, str					er or Rural Route Number,
Ω	al or A s after of in b	erti	4 Homicide determined	building, etc	c. (Specify)			City or Tox	wn, State)	
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical (nner as stated. and due to the cause(s)
	To the I within 2.	Me	29b. Signature and title of pertition	11.		29c. Licenso	e number		29d. Datersigned	Month, Day, Year)
•			Much	/ mc		()	1/06		1/26/	100)
	15		STEPHEN ENTRE		eath (Nem 23a) (Type,	5- 11/11	HEAV	THE I	FARCA	stour
	Sta Regist		31. Date filed (Month, Day, Year) AUG 0 1 20	32. Jegistr	ar's Signature	redi			Md	71742

			FIG	ase iy	•							•		9.2.0.	
			For State Registrar	;	State of	Marylai					па ме	ntal Hy	giene		
					1		Ce	rtificat	e or l	Jeath			Reg. No.2	005	25015
	Physici	an.	1. Decedent's Name (First, Mid	ddle, Last)		-	Toul	100	1		2	Date of De Month	ath Day	Year	3. Time of Delath
	/Medic		OUVE				JOHI					27	18	Q5	1035
1	Examin		4a. Facility Name (If not institu	tion, give str	eet and numb	er)	1	4b. City.	Town, or	Location of [Death			ounty of Dea	(1)
			Coastaltte	SQICE	. at	relo	Ke_	-	91	Spr			W	100	mico
	Funeral		5. Social Security Number	6. Sex	7. 1 2 X F		. last birthday	If Under Months	1 Year Days	If Under 24 Hours	Min. 8	Date of Bin (Month, Da Aug - 8	th y, Year)	C	thplace (State or Foreign ountry)
	Director		220-09-1062	1	1 2 2	85	Yrs.				I	Aug. 8	1919	Ma	ryland
	and *		Usual Residence of Decedent 10a. State 10b. Cou	ntv		10c. C	ity, Town or L	ocation							10d. Inside City Limits
	sho	ŏ					comoke								1 ☐ Yes 2 🔀 No
	the N	ect	Maryland Word 10e. Street and Number	ester		FO	COHORE	10f. Zig	Code				10a Citiza	n of What C	ountry?
	with	ă		la Dos	. a				351					USA	outiny :
	eath	erai	1749 Unionvil		. Was Decede	ent Ever in I	IS 13			isnanic Origin	n? (Specif	v Yes or No			erican Indian,
	Itam Itam	Ë	1 Never Married 2 N		Armed Force	es?	J.G. 10	If Yes, spe	cify Cuba	ispanic Origin n, Mexican, F	Puerto Ri	an, etc.)		Black, Whi	
21215-0036	within 72 hours after death with the Maryland one. than "natural" or Itams 23a or 28a-1 show the Maryleal Examinar must be notified a	Completed by Funeral Director	3 Widowed 4 □ Divord		If Yes, Give Year or Date	es:		1 🗆 Yes	2 No	Specify:			S	pecify: V	Nhite
Ö	2 hou	ted	15. Dece	lent's Educa	tion		16a. Dec	edent's Usu	al Occup	ation			16b. Kind	of Business	/Industry
15	nin 7.	pie	(Specify only hig		College (1-4	or 5+)	life.	DO NOT u	se retired	during most o ()	t working				
21,	d with	E	Elementary/Secondary (0-1:	-/	College (1 4	01 017	Home	maker					Dome	stic	
	e file othe vant,	Bec	17. Father's Name (First, Midd	le, Last)						18. Mother's	s Name (I	First, Middle,	Maiden Su	ımame)	
<u>a</u>	Ald by Alenta rkad tic a	To E	Neal Thomas T	aylor					Ì	Jenn:	ie L	ouise	Steph	ens	
Maryland	2 should be filed within and Mental Hygiene. I a markad other than "raumatic avant, the Med	-	19a. Informant's Name/Relation							and Number					
	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene the free states of 28a-1 show item 27 Ia marked other than "natural", or frams 23a or 28a-1 show other traumatic avant, I're Mcdiffel Examiner must be notified at		Mary Katherin	e Trad	der		107	Fron	t Sti	reet,	Pocor	noke C	ity,	MD 218	351
ē,	of He of He r oths		20a. Method of Disposition	- 50			Place of Disp cemetery, cri	osition (Nar	me of other plac	e)	Dat	ө	20c. Loca	tion - City or	Town, State
Ĕ	Pages nent of int: If it iry or o		1 ABurial 2 ☐ Cremation 3 ☐ Other		noval from St	ate .	rst Ba				/21/2	2005	Poco	moke (City, MD
Baltimore,	그 돈 뿐 글		21. Signature of Functial Serv	ce Licensee			:	22. Name ar	nd Addres	ss of Facility	HO1	Lowarz	Malso	n Fund	eral Home,PA
ä	Depar Impo any ir		Mil.O	DI	ein			103 L:	inde	n Ave.	, Po	comoke	City	, MD 2	21851
			23a. Part1. Enter the disease shock, or heart failure. I	or complica	ations that cau	ised the dea									Approximate Interval Between
	Physician		Immediate Cause (Final	ast only one	Mot	stati	, 1	9ma	1	Cos	row				nset and Death
	/Medical		disease or condition resulting in death)	a.	Due to (or	as a conse	quence of):	1000							0.412
	Examiner														
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is its lead to the cause).	J 0.	Due to (or	as a conse	quence of):								
	d d ansit	Examiner	Cause (Disease or injury that initiated events	1											
o,	be executed ician and burial-transit		resulting in death) Last		Due to (or	as a conse	quence of):								
760,	certificate be executed Iding physician and Ise as the burial-transi	cai		d.											
68	death certificate attending physical for use as the total for the total	Physician/Medi													
Вох	h cer endir r use	Ju.	IF FEMALE: 23b. Was decedent pregnant	230	lf yes, outco			□Ectopic p	regnancy				230	d. Date of de	,
_	deat ne att ad for	sicis	in the past 12 months? 1 □ Yes 2 No		4☐Pregnar	nt at time of		Other (sp						Month	Day Year
P.O.	at the by the	hys	9 □ Unknown												
	requires that the death een signed by the atter hould be detached for u	by F	Part II. Other significant cond	litions contr	ibuting to dea	th but not re	sulting in the	underlying o	cause giv	en in Part I.			~		o the cause of death?
pro	w require been sig should b	ed										10	Yes 2/1	No 3∏P	robably 4 Unknown
ပ္တ	aw is b	pie										24a. Was	an 2	24b. Were a	utopsy findings available completion of cause of
ď	The late has page	Completed											rmed?	death?	_/
ita	ician: Th certificate rector, pag	Bec	25. Was case referred to med	ical						26. Place of	f Death (Check only o			
†	S S	To	examiner?	Ho	spital:	patient 2	☐ER/Outpati	ent 3 DC	OA Oth	er: 4 🗆 Nursi	ing Home	5 Resi	dence 6	Other (Spe	ecify)
0			27. Manner of Death Natural 5 ☐ Per	ding	28a. Date of (Month,	Injury Day Year)	28b. Time Injury		28c. Injun Worl	at /	28	d. Describe	now injury o	ccurred	
Ö	Attanding r death. sctor: After y the fune	atic	2 Accident inve	estigation				М	1 🔲	Yes 2 □ No					
Division of Vital Records,	r Att	Certification:		ald not be ermined	28e. Place o building	f Injury - At I g, etc. <i>(Spec</i>	nome, farm, s ify)	street, factor	y, office		28	f. Location (: City or To		lumber or R	ural Route Number,
D	rs aff	Cer													
	To tha Hospital or Attand within 24 hours after death To tha Funaral Director: completely filled in by the	ledical	(Check only 2 Medi	fying Physic	cien: To the b	est of my kr	owledge, dea	ath occurred	at the tin	ne, date and printed the printed and print	place, and	d due to the at the time.	cause(s) an	nd manner a	s stated. e to the cause(s)
	tha h tha F tha F	Med	опе)		and manne	r stated.									
	o T o	-	29b. Signature and title of cer	mer .		1/1	100			e number	-	>	290. Date s	signed (Mon	th, Day, Year)
			NA	. 60	VI		VI		N	160	4/6)		18	03
7 1	117		30. Name and address of pers	son who com		of death (Ite	m 23a) (Type	Print)	Row	1722		Salin	/	MA	21802
11	1.10		UNMU COURLL	(1)	ASTAL	F1031	/CC	TU.K	NX	1/)		156	my	1 10	510
	Chr	te	31. Date filed (Month, Day, Ye		32 Reg	gistrar's Sign	ature	1							
	اد Regist، ∍		JUL 1	9 200		4.00	<i>A A</i>		'						

... Registrar DHMH 17 Rev 1/2001

Registrar

Tasha Greenberg, 31. Date filed (Month, Day, Year)

JUL 1 8 2005



State

			For State Registrer	State of Marylan		artment of H rtificate of		F	neg. No.2005	25017
П	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of Dea Month 07	Day Year	3. Time of Death I
	/Media	al	Elois 4a. Facility Name (If not institution, give	James		4b. City. Town, o	r Location of Death	0 /	07 2005 4c. County of Death	11:04P ^M
	Examin	ier	Ft. Washington				shingtor	1	Prince G	
	Funeral		Social Security Number 6. Security Number	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	r, Year) Cou	place (State or Foreign ntry)
	Director		438-62-7025 Usual Residence of Decedent	65	Yrs.			10/21/	1939 Miss	issippi
	yland		10a. State 10b. County		y, Town or Lo					10d. Inside City Limits
	8a-fs	ctor	DC	Wa	shing					Yes 2 No
	72 hours after death with the Maryland Insturel', or Items 23a or 28a-f show disal Evaniner russ be indified at	by Funeral Director	3418 24th Stree	et. SE		10f. Zip Code 2002	20		10g. Citizen of What Cou USA	ntry?
	death ms 23	nera	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.		Hispanic Origin? (Span, Mexican, Puerto	ecity Yes or No-		
98	or Ite	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 □ Yes 2 No	Specify:	ricali, etc.)	Specify: Bla	
21215-0036	hours tural',	q pa	3 X Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	16a. Dece	dent's Usual Occur	pation		16b. Kind of Business/Ir	ndustry
215	within 72 ene. than "na he Wedis	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of work d)	ing		,
	filed with Hygiene. other than	Com	12	4	Medi	cade Ex		(5)	Governmen	ıt
and	ould be fil Mental H arked oth	Be	17. Father's Name (First, Middle, Last) Gus Coleman				Harriet	•	Maiden Sumame)	
Maryland	and Men Is marke	၉	19a. Informant's Name/Relationship (7	ype, Print)	19b, Maili	ng Address (Street			r, City or Town, State, Zi Ce Plains,	o Code)
	Health an tem 27 Is to		Terri Dade/daug	hter	8258	Bisnop	Gate Li	N Whit	ce Plains, 20695	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Enaminat must be notified at once.		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐	Domoval from State	cemetery, crei	nsition (Name of matory or other pla	сө)	Date	20c. Location - City or T	
턡	Part ant		* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen.	Α					Quantico,	
Ba	permit. Departr Imports any inje		IXA.	-/\					neral Serv	
	1		23a. Part1. Enter the disease, or my shock, or heart failure. List only	olications that caused the deat	th. Do not en	ter the mode of dying	ng, such as cardiac	or respiratory ar	n., DC 200	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Cerel	lun,	scula	- Acc	iden	J. Hente	Onset and Death
	/Medical Examiner		resulting in death)	Due lo lor as a consec	uence of):	0 0 0 6			, ,	
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (ur as a conseq	quence of):	wer.				
	nd nd transit	Examiner	that initiated events	c						
8760,	certificate be executed iding physician and ise as the burial-transit	EX	resulting in death) Last	Due to (or as a consec	(uence of):					
687	ficate physics the l	edica		d.					13	
Box (es that the death certific igned by the attending p be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta		∃Ectopic pregnanc			23d. Date of deliv	
	e death he atten	sicia	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4 Pregnant at time of c		Other (specify)	,		Month	Day Year
P.0.	requires that the een signed by th nould be detache	Phy	Part II. Other significant conditions or	ontributing to death but not res	sulting in the u	nderlying cause giv	van in Part I.	23e. Did to	bbacco use contribute to	the cause of death?
Vital Records,	uires t signe Id be d	d by			-	, , , , , , , , , , , , , , , , , , ,		1 🗆 Y	′es 2. XNo 3. Pro	bably 4 □Unknown
000	~ Q 70	Completed						24a. Was	an 24b. Were aut	opsy findings available
l Re	0 5 0	mo;						autop perfor 1 Yes	rmed? death? 2 X No 1 ☐ Yes	ompletion of cause of
/ita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		C#	26. Place of Deat			
of	Phys ral di	. To	1 ☐ Yes ②X No 27. Manner of Death	I K inpatient 2	ER/Outpatier 28b. Time o	IL 3 DOA	and the second second		lence 6 Other (Speci low injury occurred	(fy)
ion	Attending Ph r death. ector: After th by the funeral	ation	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Wo	rk?]Yes 2 □No			
Division	r Attendi	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, st.	reet, factory, office		28f. Location (S City or Tox	Street and Number or Run on, State)	al Route Number,
D	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		On Continue ATI Continue Di							
	24 ho 24 ho e Fun etely f	edical		ysician: To the best of my kno niner: On the basis of examina and manner stated.						
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1		29c. Licens	se number		29d. Date signed (Month)	Day, Year)
)			· /X	11/000		D3	36061		7/9/05	
	AM			completed cause of death (Iter						
	- CA	ate	Cynthia R. Moro		enn. ature	Ave SE	#340 Was	hingto	n DC 2000:	3-4318
	St Regist	ate rar		32. Registrar's Signi	Jet 1	porte				

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 16, 2005 ear July **Physician** 16:45P Jones-Newland /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08-18-1931 9. Birthplace (State or Eoreign Country Port - Loko Sierra Leone 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min 1□M 2K F Months Days Hours 73 Director 215-08-3001 Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10d, Inside City Limits 10a State 28e-f show other treumatic event, the Medical Examiner must be notified at Ft. Washington 1 Yes 2 □ No Prince Georges Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with it Department of Health and Mental Hygiene. Importent: if tem 27 is marked other then "normaly injury or other treumation." 20744 U.S.A. 11405 Gunpowder Dr Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🗓 No Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Government Teacher 4yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bamiejoko Jones Chailie Parker ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11405 Gunpowder Dr Ft. Washington, MD 20744 Joyce Newland/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 08-06-2005 Adelphi, MD George Washington 22. Name and Address of Facility JB Jenkins Funeral Home 21. Signature of Funeral Service Licensee 7474 Landover Rd Landover, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARTHONAYOPAY Physician /Medical CANDIOVASCULAR DIVANS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the Hospitel or Attending Physician: The law requires that the death certificate be executed physicien and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 Yes 2 No Month Dav 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification After 5 Pending investigation 1 Natural 1 🗌 Yes death. 2 🗆 No 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) efter 4 | Homicide To the Hospitel within 24 hours e To the Funerel C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier ame and address of person who completed cause of death (Item 23a) (Type, Print) 12070 OLD LINE CENTER 31. Date filed (Month, Day, Year) 1 9 2005 State Registrar

PI

ease	Type or Print in I	Black Indelible Ink.	Ensure All Copies	Are Legible
	Ctata of Mandan	ad / Danastmant of Ll	anith and Mantal Liv	.cia

-110	niy Jacr	,	For State Registrar	State of	i Marylan		artment of H <i>rtificate of L</i>		nd Mental F	lygien Reg. N	201)5	25020
		i i	Decedent's Name (First, Middle.)	Last)					2. Date of	Death			3. Time of Death
H	Physici /Medic		Anthony	Jackson					July		8, 20	Year O5	19:40 [™]
	Examin	1.0	4a. Facility Name (If not institution,	•	nber)		4b. City, Town, or		Death	4	lc. County o	f Death	
			900 block of Ow				Oxon I		4 Usa II a sa		Princ	e Geo	orge's
	Funeral		5. Social Security Number 577–88–4515	6. Sex 1 ∰ M 2 ☐ F	7. Age (In yrs. 46	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of (Month,	Day Yea	1959	9. Birthpl Count	ace (State or Foreign ny) ingtonDC
Nas	Director		Usual Residence of Decedent						nazen	,	1737	wabii	Ing combo
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10	d. Inside City Limits
	a-fel	ctor	DC		Was	shingto	on						1½ Yes 2 □ No
	death with the Maryland ims 23a or 28a-f ehow ir must be notified at	Director	10e. Street and Number				10f. Zip Code			10g. C	Citizen of W	hat Count	ry?
	ath w		800 Southern A				20032				ted S		
	ltems	Funeral	11. Marital Status	Armed Fo		.S. 13.	Was Decedent of Hi II Yes, specify Cuba	ispanic Origi in, Mexican,	in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race Black	- Amenca , White, e	
36	Irs aft	by F	1 Never Married 2 Marri 3 Widowed 4 Divorced	ed 1 ⊡Yes If Yes, Giv Year or Da	re		1 ☐ Yes 2 🖾 No	Specify:			SpecifyB	1ack	
21215-0036	72 hours after natural', or ite	ted	15. Decedent			16a. Dece	dent's Usual Occupa	ation	of warding	16b.	Kind of Bus	iness/Ind	ustry
215	within 7 ene. then *n	ple	(Specify only highes: Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	kind of work done of DO NOT use retired	during most (f)	or working				
	e filed wi Il Hygien other th	Completed	12			Auto	Mechanic				Priva		
ınd	be file ital Hy id oth	Be	17. Father's Name (First, Middle, L Edward Howell	ast)					's Name (First, Mide		en Sumame)	
yla	2 should be n and Mental ls marked (raumatic ev	유	19a. Informant's Name/Relationsh	in (Time Orien)		105 14-11	Add (C44		nie Peri		T	· · · · · · · · · · · · · · · · · · ·	0-4-1
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other then "natural," or Items 23s or 28s-f show or other traumatic event, the Modical Examinatorial be notified at	6 8	Denise Landry /				ng Address (Street a Southern						
	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny Injury or other tra		20a. Method of Disposition		20b. F	Place of Dispo	osition (Name of		Date	-	Location - 0		
Baltimore,	ages ant of it: If II	4.1	1 ★ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sc				matory or other plac Iemorial	:θ) ¦	ıly 16, 20)05 T	andow	or M	D
ati.	ortar Injur	- 1	21 Suna ne of Funeral Service L		Cen	netery	2. Name and Addres	ss of Facility	Pope Fune	era1	Home	er m	D
ä	Depermine Depe		Xaloxi,	MX	and o							20	
4,	* # # # # # # # # # # # # # # # # # # #		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causaryon each line.										
1	Physician		Immediate Cause (Final disease or condition	Che	STIMO	nés.	oscoul	eduri	2 Compr	2561	on to	ALXI	Onset and Death
18	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):							
Е	Examine		Sequentially list conditions, if any, leading to immediate	b									
	ed isit	Examlner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence ot):							
	and and	xan	that initiated events resulting in death) Last	c	or as a conseq	uence ol):							
68760,	ificate be executed g physicien and as the burial-transit												
687	ificate g phy as the	edical		0									
Вох	death certifi e ettending I id for use as	Iclan/M	IF FEMALE: 23b. Was decedent pregnant		come of pregna		75.tania asaasaa				23d. Date	ol delive	у
	ne death the ette hed for	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of d		□Ectopic pregnancy □ Other (specify)			-	Mon	th	Day Year
P.0	⇒ > ⊇	Physi	9 🗆 Unknown	9C UNKNO	JWn			_					
	8 6 9	by	Part II. Other significant conditio	ns contributing to de	eath but not res	ulting in the u	inderlying cause give	en in Part I.	*		00		e cause of death?
Vital Records,	w requires been sign should be	ted							_ _ '	☐ Yes	ZEONO :	3 🗌 Proba	ably 4 □Unknown
ec	aw as b 2 sl	Completed		· April control of the Control of th						itopsy	pr	ior to con	sy findings available appletion of cause of
E H	cate ha	ပိ							X Ye	orformed? s 2□N		Yes	2 □ No
ΖË	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe	or.	ol Death (Check on				
ō	Phys	. To	1 X Yes 2 No 27. Manner ol Death	101		ER/Outpaties 28b. Time of	nt 3LI DUA	4 🗀 Nur	sing Home 5 R			r (Specify	SCENE
Division	Attending Phirdeath. sctor: After thi	ertification:	1 Natural 5 Pending	- 11/	of Injury th (Day Year)	Injury 1	M 28c. Injun Worl		5461	ect	Jour	and in	oder t
Visi	or Attendated of the or Attend	flea	3 Suicide 6 Could n	ot be 28e. Place	of Injury - At h	ome, farm, st	reet, lactory, office		28f. Locatio	n (Street	and Numbe	r or Rural	Route Number,
Ö	s after al Dire	Cert	4 CHOMICIO	buildi	ng, etc. <i>(Specil</i>	TRET	=7		900 6	Town, Sta	Jusu	s 10	20745
	Hospital 24 hours a Funeral C etely filled	0	29a. Certifier 1 Certifyin	Physician: To the examiner: On the ba	best of my kno	wiedge, deat	h occurred at the tim	ne, date and	place, and due to t	he cause	(s) and man	ner as sta	ated.
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medic	one)	and manr	ner stated.				. Seesawee at the till				
	To To Cor	4	29b. Signature and little of certifier	1)		29c. Licenso				ate signed		
•		1	20 11000	4/W	o of dooth (t	n 22a) /T	Drinth d. T			1	ıly 09		
1			30. Name and address of person of the second	PULE IN	or death (iter	ıı ∠3a) (Type,	111 Per	ın Str	eet Balt	imor	e, Mai	rylar	nd 21201

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

JUL 1 8 2005

Leave 3: April

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1 Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year 15, Ju₁y 2005 9:40A Kamara /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1705 Cinamonteal Way Upper Marlboro Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 1 X F 64 Yrs. Director 578-17-7916 12 1940 Sierra Leone August Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f show other count be notified at 1 € Yes 2 No **Funeral Director** MD Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1705 Cinamonteal Way permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a any hijury or other traumatic event, the Medical Exportance once. 20774 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify Be Completed by 3 Widowed 4 Divorced Black. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) n House Wife Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alhaji B. Kamara Yabom Kargbo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nanah Sesay/Daughter 7331 Crestleigh Circle Alexandria Virginia 22315 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Family Plot 8/6/2005 Songo, West Africa 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 1. 23a. Part 1. Enter the insease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearth silure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NIA MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown ģ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ cate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 🗌 Yes 2 X No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner' Other: ို 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) his After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 XNatural 5 Pending death. 1 Yes 2 No investigation 2 Accident Director: 6 Could not be determined To the Hospina.

Within 24 hours after de
To the Funeral Direct 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 7/18/05 0101236213 30. Name and iddress of person who completed cause of death (Item 23a) (Type, Print) 1200 N. Howard Street Alexandria, Virginia 22304 Michael Coquia M.D. 31. Date filed (Month, Day, Year JUL 1 9 2005 32. Registrar's Signat Registrar

		1	For State Registrar	State of	Marylan	-	rtment of H		Mental Hygier	2000	25022
			Decedent's Name (First, Middle	, Last)					2. Date of Death		3. Time of Death
п	Physicia		Michael	Lee		Kase	ramn		Month	Day Year	10:18 A.M.
	/Medic Examin		4a. Facility Name (If not institution,		ber)	Rase		Location of Death		c. County of Death	4
	Lxamiii		SACred Ne	apt No	SOIT	a1.	Cumt	perLar	nd	AlleGA	MA
	Funeral		5. Social Security Number		. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birth	pplace (State or Foreign
	Director		217-78-7486	1∭M 2□F	46	Yrs.	Wionuis Days	TIOUTS IVIET.	01/16/1959	Mary!	
	p ,		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	nation				10d. Inside City Limits
	anyla shov	_			Too. On		Organi				1 X Yes 2 No
	Ba-f	Director	MD A1	legany		Cumbe	rland 10f. Zip Code		100	Citizen of What Co	untn/?
	with a or	급					Tot. Zip Code	21502	109. (USA	arto y :
	s 23	by Funeral	527 Henderso	n Avenue	lent Ever in U	S 13 V	Vas Decedent of Hi		pecify Yes or No-	14. Race - Amer	rican Indian,
10	ter d	F	1 Never Married 2 Marri	Armed Ford	es?		Vas Decedent of Hi f Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, White	e, etc.
980	ursal		3 Widowed 4 Divorced	If Yes, Give Year or Dat			I□ Yes 2X No	Specify:		Specify:	White
Ö	72 hours after death with the Maryland Inatural; or Items 23a or 28a-f show Jical Examinat must be multified at	Completed	15. Decedent	's Education			tent's Usual Occupa		ting 16b.	Kind of Business/I	ndustry
2	within 7 ene. than "r	pie	(Specify only highes Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	OO NOT use retired	l)	ang		
2	filed wi Hygien other th	Con	12			Lá	aborer			Transfer	<u>r</u>
nd	tal Hydral Hydral double eveni	Be	17. Father's Name (First, Middle,			**			ne (First, Middle, Maid	en Sumame)	D:
<u>ya</u>	should Ind Meni	⁶	Leonard	Elmer		Kasecar	-	Anna	Mae		Piper
Maryland 21215-0036	2 sh and is m	1	19a. Informant's Name/Relations			1			ral Route Number, Cit		
as	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other than "natural; or items 23a or 28a-f show or other traumatic event, the Modical Examinal must be notified at		Lisa M. Kasecamp 20a. Method of Disposition	/ Wile	20h. F		sition (Name of	Avenue, cu	mberland, Man	Location - City or	
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		1 🗆 Burial 2 🖾 Cremation		tate	cemetery, crei	natory or other plac	1 - 1 - 0		-	
븚	rtmer rtant njury	1	' 4 ☐ Donation 5 ☐ Other (S _i 21. Signature # Fueral Service		Cu	mberlan	1 Crematory	07/19,	/2005 Ci ams Family Fi	mberland l meral lome	Maryland F.A.
Ba	permi Depa impo any i		21. Signature Profesial Service		,				Cumberland, N		
			23a, Part1. Enter the disease, or	complications that ca	used the deat	th. Do not ent					Approximate
	Same.		shock, or heart failure. List Immediate Cause (Final	only one cause on ea	ch line.	V	and the second			-	Interval Between Onset and Death
	Pnysician /Medical	disease or condition									1 Kay
	Examiner			1	40 4 0011000	gaorido dij.					
		jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (c	or as a consec	quence of):					
	outed nd ransit	Examine	Cause (Disease or injury that initiated events	C						1	
Ó,	e exerian ar	EX	resulting in death) Last	Due to (c	or as a consec	quence of):					
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dicai		d							
9	ing pl	Med	IF FEMALE:							,	
Вох	eath certific attending p	an/	23b. Was decedent pregnant in the past 12 months?		rth 2 Feta	al death 3	Ectopic pregnancy	,		23d. Date of deli	very Day Year
0	at the dea by the a rtached for	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregna 9☐Unkno	unt at time of o wn	death 5L	Other (specify)				
Δ.	requires that the een signed by th nould be detache		Part II. Other significant condition	ons contributing to de	ath hut not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ds,	signe d be	d by	COPD			g	,g		1 ☐ Yes	2 No 3 Pr	obably 4 Unknown
Š	w require been si should I	ete	Aal Ch	illation				·	24a. Was an		topsy findings available
Record	has has	Completed	action 30 or						autopsy performed	prior to death?	completion of cause of
a		e Co	25. Was case referred to medica	d insufficien	ncy			OR Plans of Dog	1 ☐ Yes 2 X ath (Check only one)	No 1 ☐ Yes	2 □ No
Vital	Physician: this certific ral director,	o Be	examiner?		npatient 2	ER/Outpatie	nt 3 DOA Oth	oc.	lome 5 ☐ Residence	6 Other (Spe	cify)
of		\vdash	27. Manner of Death	28a. Date o	f Injury	28b. Time o	f 28c. Injur	y at	28d. Describe how in		sily/
ion		ation	1 Natural 5 Pendir 2 Accident investi	ig .	h, Day Year)	Injury	M 1	Yes 2 □ No			
Division	f or Attendi after death. Director: A I in by the fu	iffic	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	Lincal 200. Flace	of Injury - At h	ome, farm, st	reet, factory, office		28f. Location (Street City or Town, S		ıral Route Number,
Ö	talor safte al Dir ed in	Certification:	T T T T T T T T T T T T T T T T T T T	- Canali		· <i>y</i> /					
	hour uner uner								e, and due to the cause arred at the time, date		
	To the Hospital or within 24 hours affer To the Funeral Dir. completely filled in I	Medical	one)	and mann							
	To To con	2	29b. Signature and title of certifie	2 Al			29c. Licens			Date signed (Mont	n, Day, rear)
•	٥		Jun 1C	OMIMB			00	10216		7/16/05	
	61		30. Name and address of person	who completed cause		m 23a) (Type,	Print)	Ac C	umberland	MN	
	C+	ate	31. Date filed (Month, Day, Year,		egistrar's Sign	ature	Seton (٠١. ٢)	7710	
	Regist		JUL 1		A Carlos Care	15	Genet !				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** PM 6:10 Komatz Donna 18 2005 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** City Johns Hopkins Hospital Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Min 1 ☐ M 2 🗙 F Days Hours Director 63 Maryland 220-40-3768 14-Sep-1941 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County f show in then "neturel", or items 23a or 28a-f show 1 ☐ Yes 2 No Director Allegany Frostburg Maryland 10e. Street and Number 10613 Komatz Drive, S.W. 10f. Zip Code 10g. Citizen of What Country? 21532-U.S.A Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of nent of Health and Mentat Hygiene.
ent: If item 27 is marked other then "neturel", or item try or other treumetic event, the Medical Executival. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) education principal Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Donald Williams Mabel Wynn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10613 Komatz Drive, husband Frostburg 21532 Ronald F. Komatz, Sr. Maryland 20b. Place of isposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of importent: if any injury or 22-Jul-2005 LaVale Maryland 4 ☐ Donation 5 ☐ Other (Specify) Restlawn Memorial Gardens 21. Signature of Funeral Service 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** leukemia disease or condition resulting in death) 2 years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons- uence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 the attending physician Physician/Medical as esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year ö 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 2 No 1 Yes 2 No Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 1 ☐ Yes 2 ☑ No 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide after within 24 hours a To the Funerei 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 18,2005 D60203 מיון מאושנונו 30. Name and address of person completed cause of death (Item 23a) (Type, Print) 10 1650 Orleans Street Johns Hopkins CRB-186 Baltimore, MD Jue gens State

Registrar

			State of Ma	-	epartment of H		Mental Hyg	giene	
			Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of	Death	2. Date of Dea	Reg. No	5 25025
	Physici		William Kelle	À			Month	Day Ye	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	11 .	4b. City, Town, o	r Location of De	ath	4c. County of E	7.
			Easton Memorial	40Spit	il LA	STON		190	67
	Funeral Director		5. Social Security Number 6. Sex 7. Age 219 62 9717 51	(In yrs. last birtho	Months Days	Hours Mi		y, Year)	Birthplace (State or Foreign Country) Maryland
	D		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town o	-1				10d. Inside City Limits
	Aaryla I shov	ō	Md. Caroline	Toc. City, Town C	Preston				1 Tyes 2 No
	r 28a-	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of Wha	
	death with the Maryland ims 23a or 28a-f show findst be collided at		23190 Grove Road		21655			U.S.	
	er des Items	Funeral	11. Marital Status 12. Was Decedent E Armed Forces? 1 ☑ Yes 2 ☑ Narried	ver in U.S.	 Was Decedent of H If Yes, specify Cuba 	lispanic Origin? an, Mexican, Pu	(Specify Yes or No arto Rican, etc.)	- 14. Race - / Black, V	American Indian, Vhite, etc.
1 d M 215-0036	hours after tural', or Ite	by	Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:	Top!	Specify:	Black
5-0	72 ho natur	eted	15. Decedent's Education (Specify only highest grade completed)	1 (0	ecedent's Usual Occup	during most of w	rorking	16b. Kind of Busin	ess/Industry
121	within 72 ene. than "nai	Completed	Elementary/Secondary (0-12) College (1-4or 5- 1 2 Trade Sch	-)	fe. DO NOT use retired Ca	rpente	er	Constru	uction
Jd 2	iges 1 and 2 should be filed within 72 hours after death with the Marylan to Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event. It is Marical Examinational by confilled at	Be Co	17. Father's Name (First, Middle, Last) Homer L. Kelley	1			ame (First, Middle,		
July	2 should be f and Mental I is marked of raumatic eve	To		401.1	A		lozelle	Walker	- 7:- 0:- d-1
Z Z	id 2 sh Ith and 27 is m traum		19a. Informant's Name/Relationship (Type, Print) Mozelle Kelley (mother)		Mailing Address (Street 190 Grove				Land 21655
ie (c	s 1 and 2 of Health item 27 l		20a. Method of Disposition		isposition (Name of crematory or other place		Date	20c. Location - City	
im C	Pages ment of ant; If it ury or o		1 Burial 2 □ Cremation 3 □ Removal from State One of the Control of the Contr	Coppi	n's Ch Ce	m 07	19 2005		on. Maryland
Balt	permit. Pages Department of i Important; if its any injury or o		21. Signature of Funeral Service Licensee	riell	22. Name and Addre				l Funeral
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	9. 1	i		1		Approximate Interval Between Onset and Death
	Physician /Medical		resulting in death)		cerebron	escular	accid	ent	Hours
	Examiner		Hyberi	consequence of					Years
	D #	iner	cause. Enter Underlying	consequence of	:				
	sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	consequence of	:				
8760,	cate be executed physician and the burial-transit	dicai E	d						
9	artifica ing ph e as th	Medi	IF FEMALE:						
P.O. Box	eath ce attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	Fetal death	3 Ectopic pregnancy	<i>(</i>		23d. Date o Month	delivery Day Year
o.	t the de by the ached	hysic	1 Yes 2 No 9 Unknown 9 Unknown						
of Vital Records, P	uires tha signed Id be det	by	Part II. Other significant conditions contributing to death but	t not resulting in t	he underlying cause giv	en in Part I.	•		te to the cause of death? Probably 4 Dunknown
000	aw req is been 2 shou	Completed					24a. Was	an 24b. Wer	e autopsy findings available to completion of cause of
= Re	The I	Com					perfo	orme@? dea	h? Yes 2 No
Vita	sician: certific	Be	25. Was case referred to medical examiner?		Ot		eath (Check only o		
	y Phys er this eral di	n: To	27. Manner of Death 28a. Date of Injury	/ 28b. Tir	ne of 28c. Injur	y at		dence 6 Other (Specify)
ion	ending sath. or: Afte	atio	1 Natural 5 ☐ Pending (Month, Day 2 ☐ Accident investigation	Year) Inj		Yes 2 ☐ No			
Division	lor Att after de Direct	Certification:	3 Suicide 6 Could not be determined 28e. Place of Inju	ry - At home, farm (Specify)	n, street, factory, office		28f. Location (: City or Tox		r Rural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending frompietely filled in by the funeral director, page 2 should be detached for use as	edical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of 2 Medical Exeminer: On the basis of and manner star	examination and/	death occurred at the tir or investigation, in my o	me, date and pla opinion, death of	ice, and due to the courred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	<i>i</i> .	29c. Licens		7/6	29d. Date signed (A	
			Datshmi Verelyana	han !		5 7	147	JULY 14	2005
			30. Name and address of person who completed cause of de			c. E	aston, MI	21601	
	St	ate	Lakshmi Vaildtanathan, M.D. 31. Date filed (Month, Day, Year) 32. Sgistra	r's Signature	Washington	st,	, 111		
	Regist	rar	SOL TO MAN		100				

		1 - For State Registrar			of Maryla		artmen e <i>rtificat</i>				R	eg. No.	005	25026
Physici	an	1. Decedent's Name (First, Louise			r					N	Date of Dea	Day	Year	3. Time of Death
/Medio	cal	4a. Facility Name (If not ins					4h City	Town or	Location of		lly	23,	2005 ounty of Deat	11:25 A.M
Examir	ıer	925 W. Irvi			imbor)				rstov				Washin	
Funeral		5. Social Security Number	6. Se	θX	7. Age (In y	rs. last birthda		1 Year	If Under Hours		Date of Birth		9. Birt	hplace (State or Foreign
Director		561-24-8498		□м ЖЖ.ғ	81	Yrs.	Months	Days	Hours	Ma	Date of Birth Month, Day 7 11,	L924	Cali	fornia
and		Usual Residence of Deced 10a. State 10b. 0	ent County		10c.	City, Town or	Location					<u> </u>		10d. Inside City Limits
Maryl f sho	to	Md.	Wash	ington		H	agers	town						1X Yes 2 □ No
with the 3a or 28a	I Director	10e. Street and Number 925 W. Irvi	n Ave	•			10f. Zip		L742		1	0g. Citize	n of What Co	
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I filed the Third is marked other than "natural", or items 23e or 28e-f show other traumatic evant, the Medical Evanth at must be usuited at	by Funeral	11. Marital Status 1 □ Never Married 2[3 ☒ Widowed 4 □ Di		Armed F	2 X No ive	U.S. 13	I. Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:	igin? (Specify n, Puerto Rica	Yes or No- n, etc.)		. Race - Ame Black, White pecify: V	
vithin 72 ho ne. han "natur ne Medical I	Completed	(Specify only Elementary/Secondary (de completed) (1-4or 5+)	16a. Dec (Giv life		rk done o se retired	ation furing mos)	st of working			of Business/	Industry
Hiled v Hygie thar t		12 17. Father's Name (First, M	1iddle, Last)				Art:	lst	18. Mothe	er's Name (Fir	st. Middle.		Arts umame)	
ld be f ental l ked of ic eva	To Be	Frederick									tha Po			
nd 2 shou lth and M 27 is mar traumat	-	19a. Informant's Name/Re	lationship (7	Type, Print)						er or Rural Ro				
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or othar tra		20a. Method of Disposition 1 Durial 2 Crem 4 Donation 5 0	ation 3 🗌		State	Place of Dis cemetery, cr	ematory or c	ther place		July 2	8,		tion - City or	
nit. P artme ortan injuri		21. Signature of Funeral S					22. Name ar			2005 by	121		hsburg	y Ave.
Per Jany Per Per Jany Per Per Jany Per	_	1 Park	1-	Davis	Mol	414 3	.L. D	avis	Fune	ral Ho	me Sm:	ithsl	ourg,Mc	1. 21783
Physician Medical Examiner Who private transit transi	ical Examiner	disease or condition resulting in death) Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	S.	b. Due to	(or as a cons	sequence of):	eulce		2					of the at a
ne death certific the attending p	Physician/Medic	IF FEMALE: 23b. Was decedent pregn in the past 12 months 1 □ Yes 2 ☑ No 9 □ Unknown			birth 2□F nant at time o	etal death 3	B⊟Ectopic pi i □ Other (sp					23	d. Date of del Month	ivery Day Year
uires that the signed by all did be detact	by	Part II. Other significant c	onditions c	ontributing to	death but not	resulting in the	underlying o	ause give	en in Part I	l.	23e. Did to		/	the cause of death?
sician: The law requires certificate has been sirector, page 2 should	Completed	-									24a. Was a autops perfori 1 Yes	sv	24b. Were au prior to death?	utopsy findings available completion of cause of
ding Physician: The h. After this certificate h. funeral director, page	Be	25. Was case referred to resummer?	nedical	Hospital:				Othe	260	e of Death (Ch	/			
Phys this c	은	1 Tyes 2 No 27. Manner of Death		28a. Date		28b. Time		JA	4 NU	ursing Home	5 Reside		Other (Spec	cify)
ding th. Th.	tion	1 Natural 5	Pending investigation	(Mo	nth, Day Year) Injury	м	28c. injury Work 1 🔲 `	<br Yes 2 □		DOSONDO III	or injury	30001100	
or Atten after deat Diractor:	Certification:	3 Suicide 6	Could not be determined	9 28e. Plac	e of Injury - A ding, etc. (Spe	t home, farm,	street, factor	y, office			Location (S City or Tow		Number or Au	ıral Route Number,
To the Hospital or Attending Physicien: within 24 hours after death or To the Funaral Director. After this certifics completely filled in by the funeral director,	edical C	29a. Certifier 1 C (Check only 2 M	ertifying Ph edicel Exen	niner: On the	e best of my basis of exam	knowledge, de ination and/or	ath occurred investigation	at the tim	ne, date an pinion, dea	nd place, and o ath occurred at	due to the c t the time, d	ause(s) ar ate and p	nd manner as lace, and due	stated. to the cause(s)
To th Within To th comp	Me	29b. Signature and title of	certifier	1 -			29	c. License	e number		2	9d. Date		h, Day, Year)
		> Much	ver (1. 2	rehen	N	10	0	410	667		-	> 2	6.05
12		30. Name and address of	- 1	completed cau	Ise of death (I	tem 23a) (Typ	e, Print)	/	ned	1,2.1	(in a	10 V	ltz.	estrumen
Sta	ate	31. Date filed (Month, Day	-	32.	Registrar's Si	gnature	made D			• .	- 176	r		
Regist		AUG (1 200	15 Lies	1180 1	J. 490								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 2005 Joseph _Roger July 14, Lyon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2012 Powhatan Road West Hyattsville If Under 1 Year | If Under 24 Hrs. Prince Georges 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 15 M 2 ☐ F Yrs. Director 577-05-5706 87 July 19,1917 Washington, DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28e-f show many injury or other treumatic event, the Medical Exami are must be rectified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2€ No Directo Maryland | Prince Georges West Hyattsville 10e. Street and Number 10g. Citizen of What Country? 2012 Powhatan Road 20782 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Roger Lyon Starling Carolyn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wife 2012 Powhatan Road West Hyattsville MD <u>Lillian Marie Lyon</u> 20782 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Jul, 18, 2005 Silver Spring, Maryland Cemeterv 21. Signature of Funeral Service Licensee 22. Name and Address of Facili John Colles May Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring. MD 20901 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Due to (or as a consequence of): 8 Weeks /Medical Examiner NEPHROSCLERUSIS Years Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of) be detached for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ARTERY DISEASE CORONARY 1 Yes 2 10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 12 No 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funerel D

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

10

State

Medical

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

David M. Goldman, M.D.

Registrar DHMH 17 Rev 1/2001

32. gistrar's Signature

Toldman, M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

ORIGINAL

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D000 4374

7500 Hanover Parkway Greenbelt, Maryland 20770-2011

29d. Date signed (Month, Day, Year) 7/15/2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day July 17,2005 Carl Douglas Lee /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Bon Secours Hospital Baltimore **Baltimore** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days **™** M 2□ F 53 Director May 24,1952 414-88-7747 WV Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hyglene.
and if it am 27 is marked other than "natural", or items 23s or 28a-f show and if it is the contrast reamatic event, if is Maclea Examiner mails be multiped at 1 Kes 2 No MD Baltimore Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. Fayette St. 21202 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No Dates If Yes, Give Year or Dates: Unknown 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Construction Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 George T. Lee, Sr. Hallie G. Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Troy Lee, III/newphew 134 Carters Mill Rd., Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Department in portant: if any injury or orce. R.A. Ferris, Inc. July 20,2005 West Chester, PA 21. Signature of Figure Service Licensee 22. Name and Address of Facility XXX Andrew G. Gee Funeral Home 23a. Part 1. Enter the disease, or a milications that caused the death. Do not each 19 m and 1 Marian as Shee or restriction, troub. MD shock, or hard failure. List only one cause on each line. 21 202 dimate Interval Between Onset and Death Immediate Cause (Final Se12Ure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner acidosis QV Metabolic Sequentially list conditions, if any, leading to immediate cause. Erries underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a tor use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 2☑No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this ate of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No tilled in by the f 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10060292 7/03 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore. Baltimore St Memakor 2000 w. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 1 9 2005 Registrar

			For State	State of M	arylan		artment of F	Health and	Mental Hy	-	200	E 05000
	Physici	ian	1. Decedent's Name (First, Midd Mark Everet	_			imodic or	Douth	2. Date of D. Month July	Reg. No eath 07		3. Time of Death 5 11:17 PM
	/Medi Examir		4a. Facility Name (If not institutio)		4b. City, Town, o	or Location of Deat			County of De	
	Funeral Director		Southern Maryla 5. Social Security Number 577-88-7356	6. Sex 7. Ag	ge (In yrs. i 40	last birthday) Yrs.	Clinte If Under 1 Year Months Days		8. Date of Bi (Month, D Sept. 1	rth ay, Year) 0,19	rince (George's lirthplece (State or Foreign Country) Ohio
	yland		Usual Residence of Decedent 10a. State 10b. County	,	10c. City	, Town or Lo	cation					10d. Inside City Limits
	he Man 28e-f at	Director	Maryland Prince	George	Cli	nton						1 Tyes 2 No
	th with t	al Dir	9625 Small Driv	ve			10f. Zip Code 20735				izen of What (.ted St	,
980	72 hours after death with the Maryland natural', or Items 23s or 28e-1 show Jisal Exami' at must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	If Voc Civo	?	1	Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2X No	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No Rican, etc.)	0-	Black, Wi	nerican Indian, nite, etc.
Maryland 21215-0036	- 100	Completed	15. Deceder (Specify only highe Elementary/Secondary (0-12) 12th	nt's Education st grade completed) College (1-4or	5+)	(Give life. l	dent's Usual Occup kind of work done DO NOT use retire Driver	pation during most of wor d)	king		ind of Busines	
nd 2	other	Be Co	17. Father's Name (First, Middle,			Track	DIIVEL	18. Mother's Nar	,			
yla	should by nd Menta marked umatic av	To	Warren Maurice 19a. Informant's Name/Relations		Sr.	405 Marilla	A 14	Thelma			kins	
	s 1 and 2 should f Heelth and Men Item 27 ta marka other treumatic	3	Thelma M. Laws					and Number or Ru ve. SE Wa				
Baltimore,	Pages 1 a ment of Hee ent: If Item ury or othe		20a. Method of Disposition 14 Burial 2 Cremation 4 Donation 5 Other (S		Ce	lace of Dispo emetery, cren	sition (Name of natory or other place emorial	ce)	Date .5/05	20c. Lo	cation - City o	or Town, State Maryland
Balt	permit. Page Department o Importent: If any injury or once.		21. Signature of Fune a Service	Licensee		Å	1exander 538 Mar11	S. Pope ooro Pike	Funeral	Home	es, P.	A. 20747
	Physician /Medical Examiner		23a. Part / Sinter the disease, or shock/or heart failure. List Immediate Cause (Final disease or condition resulting in death)			. Do not ente		ng, such as cardiac			c, III.	Approximate Interval Between Onset and Death
8760,	icate be executed physicien and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as c. Due to (or as d.								
.O. Box 6	death certii e attending ed for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)	,		2	23d. Date of d Month	elivery Day Year
<u>α</u>	w requires that the been signed by th should be deteche	þ	Part II. Other significant condition	ons contributing to death b	ut not resu	Iting in the ur	nderlying cause giv	en in Part I.	23e. Did 1		V	to the cause of death? Probably 4 □Unknown
al Reco	The lay ate has page 2	Completed							24a. Was auto perfo 1 X Yes		24b. Were a prior to death? 1 A Ye	
Z.	Physician: this certific ral director,	To Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ant 2	ER/Outpatien	t 3□ DOA Oth	er: 4 Nursing H	th (Check only o		Other (Se	on ful
Division of Vital Records,	ding After fune	Certification: T	27. Manner of Death 1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could	28a. Date of Injunction 7/7/05	y Year)	28b. Time of Injury 10:35	A M 28c. Injur Wor 1 □	y at	28d. Describe Drive	how injury	occurred in a My	ctor vehicle
Ω̈́	spital or Attendours after death		4 Homicide determ	28e. Place of Inj building, et	c. (Specify	hwa	4	ne date and place	dinte	wn, State)	1025	Rural Route Number, Rd
	To the Hospital within 24 hours a Vo the Funeral Completely filled	edical	(Check only 2 Medical one)	Examiner: On the basis o and manner sta	fexaminati	ion and/or inv	estigation, in my o	pinion, death occu	rred at the time,	date and	place, and du	e to the cause(s)
	To I with	Σ	29b. Signature and title of certifie	Hallan	wd		29c. Licens	·C.M.E.			9 signed (Mor	oth, Day, Year)
)		1 g	30. Name and address of person	who completed cause of d				, Baltimo	ore, Mar	ylan	d 2120	1
	Sta Registr	-	31. Date filed (Month, Day, Year) JUL 1 8 20	B2. Registr	ar's Signat	ure			,	7		1
DH	MH 17 Rev 1/20		301 1 6 20	05 Seen	1	Most	<i>U</i>					

DHMH 17 Rev 1/2001

ORIGINAL

		1	For State Registrar	State o	f Maryland	d / Depa <i>Cer</i>	rtment of H	lealth a Death	and Mental	Hygi	ene 0	05	2503	0
			Decedent's Name (First, Middle	, Last)					2. Date Mon	of Death	Day	Year	3. Time of Deat	
	Physicia /Medic	al		roy Lewis						1 1 y	15, 2		5:30	pΜ
	Examin	er	4a. Facility Name (If not institution. Homewood Of		Farms			erick				y of Death ederi	lck	
	Funeral Director		5. Social Security Number 131-05-0563	6. Sex 1X M 2 ☐ F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min. 8. Date 8. Mor	of Birth	(5 ^{r)}	9. Birth Sout	place (State or For Mry) Dakota	reign L
	and	-	Usual Residence of Decedent 10a. State 10b. County			, Town or Lo							10d. Inside City Lin	7
	Maryl Ied	tor	MD Fred	erick	F	rederi	ck						1 □ Yes 2 🗖	No
	with the 3a or 286	Il Direc	10e. Street and Number 7404 Willow Ro	ad			10f. Zip Code 2.1	702		10	g. Citizen o U • S	What Cou	intry?	
36	be filed within 72 hours after death with the Maryland Hygiene. A Hygiene. A contect then "naturel; or items 23s or 28s-f show event, Its Madical Exandrer must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 X Marr 3 Widowed 4 Divorced	Armed F	2□NoWWI:	Г	Vas Decedent of I I Yes, specify Cub I ☐ Yes 2 XNo		igin? (Specify Yes n, Puerto Rican, e	or No-		ack, White	can Indian, , etc. nite	
2-00	72 hou nature iical E	eted	15. Decedent	's Education		16a. Deced	lent's Usual Occu kind of work done OO NOT use retire	pation during mos	st of working	1	6b. Kind of	Business/li	ndustry	
7	within ane. then "	Completed	Elementary/Secondary (0-12)		1-4or 5+)		oo not use retire es Manag				Simbe	rkofi	E Sales C	Co.
	0 = 0 \$	Be	17. Father's Name (First, Middle, Roy Lewis	Last)				,	er's Name (First, I Hazel M	Middle, N Wo1	laiden Suma É	ame)		
Mary	d 2 should be in the and Mental I	2	19a. Informant's Name/Relations Richard Lewis	hip (Type, Print) (Son)		19b. Mailir 930	ng Address <i>(Str</i> ee 4 Huntma	and Number	er or Rural Route Road Lay	Number,	City or Tow	n, State, Zi	p Code) 20882-13	345
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 lie marked any injury or other traumatic e once.		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S		_ 0	emetery, crei	sition (Name of natory or other pla rg Crema	tory	Date 7-16-05		Smiths	-		
Baltii	permit. I Departm Importer any injui		21. Signature of Funeral Services		reply	RC	BERT E.	DAILE	ity Y & SON ST. FRED	FUNE ERIC	RAL HO	OMES,	P.A.	
}	Pnysician /Medical		23a. Part 1. Enter the disease, shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	_a. 44	caused the death each line.	n. Do not ent	er the mode of dy	ing, such as	s cardiac or respira	tory arre	st,		Approximate Interval Between Onset and Death	th
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to	Cor of a conseq	uence of):	dur	0					2 day	15
8760,	ate be executed hysician and the burial-transit	ai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):								
687	tificate ng phys as the	edic		d										
O. Box	death cer e attendir sd for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	utcome of pregna birth 2 Feta mant at time of d	Ideath 3[Ectopic pregnant Other (specify)	су				Date of deli Month	very Day Year	
۵.	requires that the dien signed by the hould be detached	b		sons	Disc	ulting in the u		iven in Part	1. 23	e. Did tob	2/		the cause of death	
Vital Records,	: The taw requir cate has been s page 2 should	Completed	Dem	ent.a						a. Was a autops perform	y	o. Were au prior to d death? 1 \(\text{Yes}	topsy findings avail completion of cause 2000	ilable e of
/ita	Physicien: this certificaral director, it	Be (25. Was case referred to medica examiner?	Heapitals			0		e of Death (Chec			Hes.		
of	Physic rthis ral dir	. To	1 Yes 2 No 27. Manner of Death	1	Inpatient 2 e of Injury nth, Day Year)	28b. Time o	f 28c. Inj	ary at	Jursing Home 5		ince 6 ∐0 ow_injury occ		cify)	
ion	Attending Ph r death. ector: After th by the funeral	ation	Z Z TOOIGOIN	gation 7-1	nth, Day Year) 3 OS	300		ork?]Yes 2	two fel	11.4	ron	1 t	red	
Division	of or Attendir safter death. I Director: Af d in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be nined 28e. Plac buil	ce of Injury - At hiding, etc. (Special	ome, farm, st	reet, factory, office)	28f. Loc City	or Town	, State)	mber or Ru	ral Route Number,	
	To the Hospitel or Attervalue of the Vertical To the Funerel Director Completely filled in by the	ledical Ce	(Check only 2 Medicel	ng Physicien: To the Exeminer: On the	basis of examina	wiedde, dea	th occurred at the ovestigation, in my	time, date a opinion, de	and place, and due the occurred at the	to the ca	ause(s) and ate and place	manner as e, and due	stated. to the cause(s)	Gl.
	To the within 2 To the comple	Med	29b. Signature and title of certifie	-	nner stated.	AID	29c. Licer	se number					n, Day, Year)	5
1	2+1		30. Name and address of person	who completed ca	use of death (Item	n 23a) (Type	Print)	, 7	th St.	204	F	· An	-200	>
*		ate rar	31. Date filed (Month, Day, Year	9 2005	F gistrar's Signa	ature	Sound!	,	217	~_/_				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		For State Registrar	State of Marylan		nent of F cate of			Reg. No 20	
Physic /Med		1. Decedent's Name (First, Middle, Las	•	cclear	Υ		2. Date of De Month	Day	Year Vol. 12 M
Exami Funeral Director	ner	4a. Facility Name (If not institution, give The Johns Hop 5. Social Security Number 6. Se	Kins Hosp	last birthday) If	City, Town, o	If Under 24 Hrs Hours Min.	CITY 8. Date of Bi	4c. County	of Death 9. Birthplace (State or Foreign Country)
yland now		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Locatio	'n				10d. Inside City Limits
he Mar 28a-f sh	Director	PA YORK		YORK	Of. Zip Code			10g. Citizen of W	1 Yes 25 No
3a or	ai Dir	70 DEW DROP	R'D.	i i		1403		U.S	
VILL 15-UUSO Within 72 hours after death with the Maryland jiene rithan "natural", or Items 23a or 28a-f show the Medical Examiner must be neitified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 25 No If Yes, Give Year or Dates:	i i	Decedent of F s, specify Cub Yes 2 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Race Blac Specify	e - American Indian, ck, White, etc.
Maryiand 21213-UU30 nd 2 should be ilied within 72 hours aft lih and Mental Hygiene. 27 is marked other than "natural", or rtraumatic event, tra Medical Exami	Completed	15. Decedent's Ed (Specify only highest grades)	ucation	16a. Decedent's (Give kind life. DO N	of work done IOT use retire	during most of wo d)		16b. Kind of Bu	usiness/Industry
IG Z IZ		17. Father's Name (First, Middle, Last)		PRODUC	TION S	18. Mother's Na		MANUFA Maiden Sumam	ACTURING '
yland out be filed whental Hygenthe out on the filed water out the water over the satic event,	To Be		CLEARY			MIRI		NYDER.	
re, Maryla s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (7	*					per, City or Town,	State, Zip Code)
- m		DIANE K. MCCLE	20b. I	70 DEV	n (Name of		YORK, P		City or Town, State
a a o .		1 ☐ Burial 2 ★Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	TEROSE C	•	1	1-2005	YOR	K, PA
baltimo permit. Page Department o Important: If any injury or		21. Signature of Funeral Service Licen	1.11.11	134	me and Addre	oadway	Red Lie	neral Honon, PA	17356
Physician /Medical		23a. Part1. Enter the disease, or compshock, or heart failure. List only in Immediate Cause (Final disease or condition resulting in death)							Approximate Interval Between Onset and Death Idays
firete be executed firete be executed by physician and streams the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Intrace Due to (or as a consect d.	quence of):	. m	ultifo	me		lyear
death certif de attending of for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of of 9 □ Unknown	al death 3 Ect	opic pregnanc ner (specify)	у		23d. Dat Mor	te of delivery nth Day Year
v requires that the been signed by the should be detached	by	Part II. Other significant conditions of	ontributing to death but not re	sulting in the under	lying cause gr	ven in Part I.		N 1	ribute to the cause of death? 3 Probably 4 Unknown
VICEL RECORDS, sicien: The law requires t certificate has been signe lirector, page 2 should be t	Completed						24a. Was auto perf 1 Yes	opsy ormed2	Were autopsy findings available prior to completion of cause of death?
r VI(al M) ysicien: The is certificate hi director, page	Be	25. Was case referred to medical examiner?	Hospital:		_ Ot	205	ath (Check only		
	n; To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	ry at		how injury occurr	
DIVISION (I or Attending F after death. Director: After d in by the funer.	Certification:	1 Natural 5 Pending 2 Accident 3 Suicide 4 Homicide 5 Pending investigation determined		ome, farm, street,	M 1]Yes 2 □No		(Street and Number own, State)	er or Rural Route Number,
To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one) 2 Medicel Exertifying Ph	ysician: To the best of my kn niner: On the basis of examin- and manner stated.	owledge, death occ ation and/or investi	curred at the ti	me, date and plac opinion, death occ	e, and due to the curred at the time	e cause(s) and ma , date and place, a	unner as stated. and due to the cause(s)
To th within To th compl	Me	29b. Signature and title of centifier			29c. Licen				d (Month, Day, Year)
		1 11	5	- 00a) (T 5		5-000		IN/A =	20,2005
12		Robert Hoes	completed cause of death (Ite	600 No.	th h	olfe S	teet i	3altimo	w, mD 2178.
S Posi-	tate	31. Date filed (Month, Day, Year)	32. Figistrar's Sign	ature	de				

		1 - State of Mai		artment of Hea ctificate of De			iene g. N2 0 0	5 25032
Physici		1. Decedent's Name (First, Middle, Last) Winford Andrew Maddy				2. Date of Deat Month U y		3. Time of Death 2:25P M
/Medic Examin		4a. Facility Name (If not institution, give street and number) 12013 Sunflower Ct.		4b. City, Town, or Loc Bishopvil			4c. County of	Death
Funeral Director		236-44-4566 XXM 2□F 7	(In yrs. last birthday) 4 Yrs.	If Under 1 Year If U	Under 24 Hrs.	8. Date of Birth (Month, Day, SEPT. 2	1, 1930	B. Birthplace (State or Foreign Country) West Virginia
Maryland f show	or	Usual Residence of Decedent	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2/☐ No
with the Maryland a or 28a-f show	Direct	10e. Street and Number	b13Пору 1	10f. Zip Code		1	0g. Citizen of Wh	at Country?
filed within 72 hours after death with the Maryland Hygiene. Hygiene. I have naturel; or Items 23a or 28a-f show ent, Ite Madical Examinating Leasantied at	Funeral Director	12013 Sunflower Ct., 11. Marital Status 1 □ Never Married 2 ☑ Married 12. Was Decedent Exammed Forces? 1 □ Yes 2 ☑ Norther (Fyes, Give		21813 Was Decedent of Hispar of Yes, specify Cuban, M 1 ☐ Yes 2 1 No Si	nic Origin? (Spec Mexican, Puerto R	cify Yes or No- lican, etc.)	Black,	American Indian, White, etc. White
within 72 hours jiene. r then "naturel", Ine Medical Exe	Completed by	3 Wildowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	16a. Decec (Give	dent's Usual Occupation kind of work done during DO NOT use retired)	· · ·	g	16b. Kind of Busin	
led withir lygiene. her then nt, Ire M		Elementary/Secondary (0-12) College (1-4or 5+)	President	Mathada Nama	/Final Middle I		Company
permit. Pages 1 and 2 should be filed with Department of Health and Mental Highen with Importent: If tem 27 is marked other thea any injury or other treumatic event, ITEM ODGE.	To Be	17. Father's Name (First, Middle, Last) Waldo Maddy		M	argie Sm	ith	Maiden Sumame)	
and 2 sh ealth and m 27 Is n		19a. Informant's Name/Relationship (Type, Print) Margaret A. Maddy (Wife)		ng Address (Street and I				
Pages 1 and of Healers 1 and 1		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from State	1	natory or other place)			20c. Location - Ci	
nit. Pa artmen ortent: injury e.		` 4 □ Donation 5 □ Other (Specify) 21. Signature of Fune II Service Licepyee		open Crem. Name and Address of	7-19-		rankford	-
permit. Departr Importe any inji		N. Bila/ Durbase		108 Willia	m St., B	erlin,	Md. 218	
value en en en		23a. P. 1. Ener le diseas , or complications that caused the shock, or heart fallure. List only one cause on each line. Immediate Cause (Final	he death. Do not ent	er the mode of dying, su	uch as cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	consequence of):	Mary	Dist	ASC		
Examiner	Examiner	cause. Enter Underlying Cause (Disease or injury	consequence of):	eval /	Rifur	2		
rate be executed only sician and the burial-transit	dicai Exar	that initiated events C.	consequence of):					
ath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	,
uires that the de signed by the a	ρχ	Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause given in	n Part I.			ute to the cause of death?
	Completed					24a. Was a autops perform	ned? dea	ore autopsy findings available or to completion of cause of ath? Yes 2 \sum No
ysicien: The is certificate hidrector, page	Be	25. Was case referred to medical examiner? Hospital:	• • • • • • • • • • • • • • • • • • •	Othor	. Place of Death			
ng Ph Ifter th	ation: To	1 ☐ Yes 2X No Trospital. 1 ☐ Inpatient 27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation 1 ☐ Inpatient 28a. Date of Injury (Month, Day)		28c. Injury at Work?			ence 6 Other ow injury occurred	
To the Hospitel or Attending P within 24 hours after death. To the Funeral Director: After toompletely filled in by the funeral	Certification:	a Could not be	y - At home, farm, str (Specify)	eet, factory, office	2	8f. Location (St City or Town	reet and Number n, State)	or Rural Route Number,
To the Hospitel within 24 hours a To the Funerel I completely filled	edicai	29a. Certifier (Check only one) Certifying Physicien: To the best of and manner state	examination and/or in-	n occurred at the time, divestigation, in my opinio	date and place, as on, death occurre	nd due to the ca d at the time, da	ause(s) and mannate and place, and	ner as stated. d due to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier		29c. License nui	imber	2	9d. Date signed (Month, Day, Year)
ìr		30. Name and oddress of person who completed cause of dea	ath (Item 23a) (Type,		1118	D	///8/	8
1.0		Jaseph B. M. Shea, Die 31. Date filed (Month, Day, Year). 32. Agistrar	o 10570 's Signature	1' RACETILI	tick Ro	Bei	lin, Me	021811
Sta Registi		JUL 1 8 2005	J J A	node				

			1- State of Maryland / Department State of Maryland / Department Certification	ent of He		_	jiene	005	0=0	0.0
Ī	Dhuaisi		Decedent's Name (First, Middle, Last)			2. Date of Dea Month	th Day	Year	(3. Timed	Death)
	Physicia /Medic		Charlson Mehl	0) T		July	13,	2005	5:45	AM
	Examin	ier		lney	ocation of Death			County of Death ntgomer	V	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Un	nder 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth			place (State o	r Foreign
	Director		578-20-4930 1™ 2□F 86 Yrs. Mont	ths Days	Hours Min.	8. Date of Birth (Month, Day 03/17/1	919	Wash	ington	, DC
	and W		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location						10d. Inside Cit	ty Limits
	Maryl -1 sho	tor	MD Montgomery Silver Sprin	ng					1 🗆 Yes	2 X No
	th the	irec		f. Zip Code		1	_	en of What Cou	ntry?	
	ath wil	rai		20906		-7.14	7	U.S.A.	Indian	
30	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentalle Hygiene. Important: If tien 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Moulcal Examiner must be notified alonge.	by Funeral Director	Armed Forces? If Yes, s	specify Cuban,	panic Origin? (Spo Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		4. Race - Americ Black, White, Specify: Wh	etc.	
2-003p	72 hou		15. Decedent's Education 16a. Decedent's L (Specify only highest grade completed) (Give kind of		on ring most of work	ina	16b. Kin	d of Business/In	dustry	
7	ithin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NO	OT use retired)	3			truction	n Trade	е
7	illed w Hygier ther tl nt, III		17. Father's Name (First, Middle, Last)		8. Mother's Name			ciation Gumame)		
au	ld be lental l	To Be	Joseph Martin Mehl		Lenora C	harlson				
ary	shou and M a mar	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addr							
Σ αν	and 2 tealth m 27 in		Erric Mehl - Son 3602 Liv	- 50				ng, MD		
0	if ite		1 ☐ Burial 2 X Cremation 3 ☐ Removal from State	or other place)	!					ıd
Saitimore	artmer artmer ortant injury				of Facility Sin)	-
ñ	Dep imp any		1040	Rockvil	lle Pike	, Rockvi	11e,	Maryla	nd 208	52
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the r shock, or heart failure. List only one cause on each line.	mode of dying,	such as cardiac	or respiratory arr	est.		Approximate Interval Bety Onset and D	ween
. 1	Pirysician		Immediate Cause (Final disease or condition a. Conjective Meurt)	Frilare						eles
	/Medical Examiner		Due to (or as a consequence of):	0					Ve.	c = 5
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	v. sein						20 2
	ocuted nd transit	Examiner	Cause (Disease or injury that initiated events c.							
8/00,	certificate be executed ding physician and use as the burial-transit		resulting in death) Last Due to (or as a consequence of):							
200	ficate physics the	edical	d							
ZOZ	w requires that the death certific been signed by the attending p should be detached for use as:	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopi	oic pregnancy			23	3d. Date of deliv		V
	e death the atten	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown					Month	Day Y	Year
Į.	requires that the leen signed by th hould be detache	, Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying	ing cause given	in Part I.	23e. Did to	bacco us	e contribute to t	he cause of d	eath?
cords,	tuires n sign	d by	Pleur Offician			1 (X (Y	es 2	No 3□Prol	bably 4 □U	Jnknown
* *	law rec as bee	ompleted				24a. Was a autops		24b. Were auto	opsy findings a	
Ĭ	The aate ha	Com				perfor	med? 2□ No	death? 1 ☐ Yes	2 X No	
VII	ician: sertific ector,	Be	25. Was case referred to medical examiner?	Other	26. Place of Deatl					
0	Phya r this ral dir	. To	27 Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury a Work?	4 Nursing Ho	me 5 Residence 128d. Describe he			<i>y</i>)	
0	nding ath. r: Afte e fune	atlor	1 Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation M		s 2 No					
DIVISION	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2 or	ertification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fact building, etc. (Specify)	ctory, office		28f. Location (S City or Tow		Number or Run	al Route Num	ber,
	pitai o	0	29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occur	urrad at the time	date and place	and due to the c	ause(s) a	and manner as s	stated	
	e Hos 24 ho e Fun letely i	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigal and manner stated.)
	To th within To th compl	Me	29b. Signature and title of certifier	29c. License r				signed (Month,		
	12+1		riched Neural W	D	42777		Jul	1 13,2		
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Pond I	0.00/277411	o Marr-1	ar J	20050		
	Sta	ate	Richard Weinstein MD, 15225 Shady Grove 31. Date filed (Month, Day, Year) 32 Registrar's Signature	Noau, h	NOCKV111	e, Maryl	Land	40630		
	Registr		31. Date filed (Month, Day, Year) JUL 18 2005 32 Registrar's Signature	1						

			1 - State Registrar	State of Mar				lealth a	and M		giene Reg. Nø		5	250	34
			Decedent's Name (First, Middle, La	st)						2. Date of De	eath			3. Time of	Death
	Physici		Tommie	Mobley						Month July	13.	200	Year 5	3:53	Ам
1	/Medic Examin		4a. Facility Name (If not institution, give			4b. Cit	y, Town, or	Location o	f Death			County o			
	Examin	-	Fairland Nursing	Home		Si	.lver	Sprin	ng			Mont			
-	Funeral			Sex 7. Age (In yrs. last birthda		er 1 Year	If Under		8. Date of Bi (Month, Date Jan. 1	ith ay, Year)		9. Birthp	olace (State o ntry) rida	r Foreign
t	Director		254-20-7816	X M 2□F	81 Yrs.	- Wilding	5.00			Jan. 1	5, 1	924	F1c	rida	
	pu 🖈		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or	Location							Τ,	0d. Inside C	ity Limits
	aryla ehov	5													2 🗆 No
	the N 28a-f	ect	Maryland Montgon 10e. Street and Number	ery	Silver		ip Code				10g. Cit	izen of Wi	hat Cou	ntry?	
	a or	급	2101 Fairland Ro	ad			0904				_	ited			
	filed within 72 hours after death with the Maryland Hygiene ther then "natural", or Items 23a or 28a-1 ehow ther then medical Examine must be motified at	Funeral Director	11. Marital Status	12. Was Decedent Ev	er in U.S.			ispanic Ori	gin? (Spe	cify Yes or Ni Rican, etc.)		14. Race	- Americ	can Indian,	
10	r Iten	Fun	1 Never Married 2 Married	Yes 2 No					, Puerto I	Rican, etc.)			, White,		
99	al', o	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1965	1 ∐ Yes	2 XNo	Specify:				Specify:	вта	CK	_
0	72 ho	ted	15. Decedent's E (Specify only highest gr	ducation	(Gi	cedent's Us	vork done	durina mosi	t of workir	na	16b. K	ind of Bus	iness/In	dustry	
2	ithin 19.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life	. DO NOT	use retired	1)				A			
Ŋ	ed wygien ygien ver th	Completed	12		So	ldier	•	40 Marks	de Nome	(First, Middle		Army			
n a	be fill H d oth	Be	17. Father's Name (First, Middle, Lasi Tommie Mobley)					e Br		e, Maiden	Surname	,		
78	ould Mer Marke natic	ဥ	-	To a Colonia	105 14-	Man Adda	an (Ctrant			I Route Numb	har Cibro	r Tourn	Stata Tir	Code	
Maryland 21215-0036	12 st h and 7 ls n traun		19a. Informant's Name/Relationship		1								207		
o,	Heal The m 2		Willie M. Mobley 20a. Method of Disposition	(wife)	20b. Place of Dis	position (A	ame of			attsvi _{late}				own, State	
ğ	Ti i of		1 X Bunal 2 Cremation 3 ['4 Donation 5 Dother (Special		cemetery, c				8/2	./05	Ar1	ingto	on.	VA	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or items 23a or 28a-f ehow any injury or other traumatic event, the Medical Exprainer must be notified at once.		21. Signature of Funeral Service Lice	^		_				ire Fu					
Ba	Dep mb mb mb) Thomas	4. Clylun	m					N.W.,				20012	
喉	*		23a. Part 1. Enter the disease, or con shock, or heart failure. List only	plications that caused th	e death. Do not									Approximati Interval Bet	le ween
	Physician		Immediate Cause (Final											Onset and	
	/Medical		disease or condition resulting in death)		ion Pneu consequence of):	mon12		-							
М	Examiner		Control Programme	b											
46	*(S)	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):										
	nd	Examiner	that initiated events	c											
760,	te be executed ysician and te burial-transit		resulting in death) Last	Due to (or as a	consequence of):										
6876	icate be executed physician and s the burial-transit	dlcal	•	d											
	that the death certifical ed by the attending phy detached for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome of	pregnancy							23d. Date	of deliv	BOV.	
Bo	atten for u	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at tir	Fetal death	B Ectopic		1				Mont			Year
o	y the d	ıysk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown			,,_								
0	that hed b deta	by Pt	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying	cause giv	en in Part I	•	23e. Did	tobacco	use contril	bute to t	he cause of	death?
rds	w requires that been signed to should be det	q p								1 🗆	Yes 2	□No :	3 🗌 Prol	pably 4X	Unknown
00	s bee	lete								24a. Was		24b. W	ere auto	psy findings	available
Re	The la	Completed								perf	opsy formed?	de	ath?	mpletion of o	ause of
ta	an: rtifica tor, p	a	25. Was case referred to medical					26. Place	of Death	(Check only					
>	Physical this ceral direction	To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1 Inpatient	2 ER/Outpat	ient 3	DOA Oth	er: 4🙀 Nu	irsing Hor	ne 5 🗆 Res	idence	6 □Othe	r (Speci	5)	
Division of Vital Records, P.O. Box	Attending Physician: The law requires that the death certifica rideath. ector: Atter this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the funeral director, page 2.		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day)	(ear) 28b. Time		28c. Injur Wor	y at k?	2	28d. Describe	how inju	ry occurre	d		
Sio	endii eath. or: A	catle	2 Accident investigation	20		М		Yes 2			10.				
$\frac{2}{2}$	or Ati	Certification:	3 Suicide 6 Could not 4 Homicide determined		/ - At home, farm, (Specify)	street, fact	ory, office		4	28f. Location City or To			r or Huri	и ноше кип	1 <i>0</i> 0 <i>r</i> ,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely illied in by the funeral director, page 2		29a. Certifier 1 Certifying P	hysician: To the best of	my knowladza do	ath occurr	ad at the ti-	ne data as	d place	and due to the	- Cauca/-) and man	ner se r	tated	
	24 ho Fun etely	Medical	(Check only 2 Medical Exa	miner: On the basis of e and manner state	xamination and/or	investigati	on, in my o	pinion, dea	th occurre	ed at the time	, date an	d place, ar	nd due t	the cause(s	s)
	To the within 2 To the complet	Me	29b. Signature and title of certifies	0 -			9c. Licens	e number			29d. Da	te signed	(Month,	Day, Year)	
1	7 L I		NO	TILL			D454	71			$J\mathbf{u}$	1y 14	4, 2	005	
7	2		30. Name and address of person who	completed cause of dea	ith (Item 23a) (Typ	e, Print)									
(5		Yeheyis Neguss	1	1111 Spr		treet	, Si1	ver	Spring	, MD				
	Sta Registr		31. Date filed (Month, Day, Year)	39. Registrar	s Signature	action									

			1 - For State Registrar	State o	f Maryland	-	artment <i>rtificate</i>						05	2502	
			Decedent's Name (First, Middle, Last)							2. Date of Death 3. Time of			3. Time of De	ath	
	Physici /Medic		Roy Michael	Myers	3						Month July	17,	2005	8:30	P^M
	Examin		A. F. W. Mary of the state of t						of Death						
			108 Boundary Ave. Apt. 13				Thurmont					Fre	Frederick		
	Funeral Director		5. Social Security Number 218-72-4175	6. Sex 1⊠ M 2□ F	7. Age (In yrs. la:		If Under 1 Months	Days	Hours	Min.	8. Date of Birth (Month, Day Sept. 28	Year)	Cou	place (State or Fe intry) y land	oreign
	and	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation						Ţ	10d. Inside City L	imits
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iteme 23e or 28e-1 show any injury or other treumatic event, the Medical Examinations to hyllied at ance.		Maryland Freder	eri o le		10f. Zip Code						12 Yes 2 □ No			
		Director	10e. Street and Number	LICK	ck Thurmont				1	Og. Citizen of	Citizen of What Country?				
		aj D	108 Boundary Ave	e., Apt.	13		21788				Unite		•		
	deel	Funeral I	11. Marital Status		edent Ever in U.S.	. 13. \	Was Decede	ent of His	panic Orig	gin? (Spe	city Yes or No- Rican, etc.)	14. Ra	ce - Amen	ican Indian,	
21215-0036	al', or it	þ	1 ☐ Never Married 2 1 Marri 3 ☐ Widowed 4 ☐ Divorced		^{2□} No /e 1978-		Yes 2		Specify:	i, rueito i	nican, etc.)		ack, White <i>ity:</i> Whi		
2-0	72 ho	To Be Completed	15. Decedent (Specify only highes		-	16a. Deced	lent's Usual kind of work	Occupat	ion	t of working	20	16b. Kind of I	Business/Ir	ndustry	
21	nen. hen *		Elementary/Secondary (0-12)	College (1	1-4or 5+)	life. L	DO NOT use	retired)	inng most	or worth	,9				
22	iled v Hygie ther t		12 17. Father's Name (First, Middle, L	act)		Food	Hand1		10 Marks	de Mane	(First Add to 1	Resta			
Maryland	d be fandal had of		Alton Monroe Mye	,				1			(First, Middle, I				
<u> </u>	shoul nd Me mark mati		19a. Informant's Name/Relationsh				Dorothy Virg								
	nd 2 : alth ar 27 is r freu		Frances E. Myers								. 13, T				
re,	s 1 a of Hea item othe		20a. Method of Disposition		20b. Pla		sition (Name			uly D		20c. Location			
Ē	permit. Page Department o Importent: If any injury or once.		1XX Burial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (Sp		State		Mem. G			20	-	Freder	ick.	Maryland	1
Baltimore,			21. Signature of Fune	icensee							rvices,				
<u>-</u>			1011	2/		95	<u>01 Cat</u>	toct	in Mt	tn. F	lwy. Fre	derick	MD	21701	
П	Physician bulleting in the price of the pric		9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between												
		disease or condition								Onset and Deat	ın				
			resulting in death)	Due to (or as a conseque	nce of):			_					1,	
		- G	Sequentially list conditions,	b. Due to (Due to for as a consequence off:									1/24.	
		min	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):												
		Еха													
8760,		dical Examiner	d												
Θ	artifica ing ph e as t	Physician/Med	IF FEMALE:				-								
Вох	death certific e attending p		23b. Was decedent pregnant in the past 12 months?	1 Live bi	come of pregnanc irth 2 ☐ Fetal d	eath 3 🗌	Ectopic preg						ate of delive	ery Day Year	
o.	0 @ 9	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregn	ant at time of dear own	th 5∐	Other (spec	cify)				-	01141	Duy 7001	
۵.		Y Ph	Part II. Other significant condition	r significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tob	acco use contribute to the cause of death?				
rds,	n signe	d by								Yes 2 No 3 Probably 4 U			ably 4 🗆 Unkn	IOWN	
Record	aw requir	Be Completed									24a. Was ar	1 24b.	Were auto	psy findings avail	able
	The lav ate has page 2										autopsy	red?	prior to co death?	mpletion of cause	of
ţ			25. Was case referred to medical examiner?					2	26. Place	of Death	1 ☐ Yes 2	/	1 🗆 Yes	2L NO	
<u>~</u>	S 0 0	10 2	1 Yes 2 No	Hospital:					sing Hom	ome 5. Pesidence 6 □ Other (Specify)					
Division of Vital	ding Ph h, After thi funeral	27. Manner of Desith 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Work?													
	Attending ar death, ector; After by the funer	2 Accident investigation M 1 Yes 2 No													
<u>></u>	l or Atten after deat Director; I in by the	Certification;	4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 See. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of Town, State)								I Route Number,				
	To the Hospitel of A within 24 hours after To the Funerel Direct completely filled in by	Medicai Ce	29a. Certifier (Check only one) 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
			one) and manner stated. 29b. Signature and title of certifler				29c. License number				29d. Date signed (Month, Day, Year)				
•			1	Cod	145		1	0 14	42			7 . 1	156	200 3	
()	10	-	30. Name and address of person w	no completed cause	e of death (Item 2	За) (Туре, Р						019	10,	<i>300 3</i>	
1	A		501 w.	473030	h Str	cet	5/2		A		reder	ck r	C.N	2170]	
	Stat Registra		31. Date filed (Month, Day, Year)	9 2005 32. Re	strar's Signatur		Court	,			-	,			

			1 - For Stata Registrar	State of M	laryland / Depa <i>Ce</i>	artment of He		ental Hygie	2005	25036	
	Physici /Medic		Decedent's Name (First, Middle, Last) Vernon Wayne Nicholson					2. Date of Death Month July 14,	Day Year 2005	3. Time of Death	
	Examin		4. Facility Manage (16 and locality along a local and a complete)					ath 4c. County of Death			
			28586 Old Quantico Rd 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24					Wicomico			
	Funeral Director		058-32-3915	1 M 2 F	ge (In yrs. last birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay, Ye 9/28/194	oar) 9. Birt Co Ma	thplace (State or Foreign buntry) Lryland	
	land	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits	
	be filed within 72 hours after deeth with the Maryland als Hygiene. Id Hygiene. Id other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notilised at		Maryland Wicomico Salisbury							1 ☐ Yes 2 🛣 No	
			10e. Street and Number 28586 Old Quantico Rd 21801						Citizen of What Co	ountry?	
36			11. Marital Status 1 □ Never Married 25 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:	?	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 No	panic Origin? (Spe Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: W		
Maryland 21215-0036			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work						16b. Kind of Business/Industry		
21	filed wi Hygien ther th		12	2	Mini	ster	O. Mathada Nama	(First Adiddle Adei	Religion		
lanc	ss 1 and 2 should of Health and Mer Itam 27 is marke r other treumatic		17. Father's Name (First, Middle, La Vernon Levi Nic			'		(First, Middle, Maid ce Dennis			
lary			19a. Informant's Name/Relationship			ng Address (Street an	d Number or Rura	l Route Number, Ci	ity or Town, State, 2	•	
			Sandra Kaye Nich 20a. Method of Disposition	olson/wife	20b. Place of Dispo	6 Old Quar	D		iry, MD 2 Location - City or		
OLL			1 Burial 2 Cremation 3		Hebron C	matory`or other place) 'emetery	7/19		ebron, MD		
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signal Poof Funeral Service Lie	ens de la company de la compan) H	2. Name and Address OLLOWAY FU 01 Snow Hi	of Facility enral Ho	me Profes	ssional As	ssociation	
	that the death certificate be executed EX Water the attending physician end detached for use as the buriat-transit detached for use as the buriat-transit	edical Certification; To Be Completed by Physician/Medical Examiner	23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between								
8760,			Immediate Cause (Final disease or condition resulting in death)	_ a	heroscler	etic On	mary (shey	M Secse	Onset and Death	
			Sequentially list conditions	b. Encl Stage Renal deserte > 34 -							
			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as							
			resulting in death) Last	cDue to (or as							
9				d							
P.O. Box			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)					23d. Date of delivery Month Day Year		
	w requires that the bean signed by should be detact		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diahetes mellinis						obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown		
al Records,	Physician: The law re this certificate has be ral director, page 2 sho							24a. Was an autopsy performed	prior to death?	ntopsy findings available completion of cause of 2 \(\square\) No	
Vital			25. Was case referred to medical examiner?	Hospital:		Other	6. Place of Death				
of	ng Phys ter this neral di		1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju	urv 28b. Time o	IL 3 DOA	4 Nuising Hon	ng Home 5 🗹 Residence 6 🗆 Other (Specify) 28d. Describe how injury occurred			
Division	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer		2 Accident investigat	be Rise of In		M 1 ☐ Ye	s 2 No	10f Leastien (Street	and Number of Di		
Div			4 Homicide determine	280. Place of In	jury - At home, farm, str tc. <i>(Specify)</i>	eet, factory, office	City or Town, Si	ocation (Street and Number or Rural Route Number, ity or Town, State)			
			29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
l .	To the within 2 To the complet	M	29b. Signature and title of certifiar			29c. License n	number	29d.	Date signed (Month		
•			30. Name and address of person wh	o completed cause of	death (Item 23a) (Tune	Print)	412-1		7/15/05		
			111 10.0.11	nn //)1	antwer .	1 8/10	by	mp Z	1804		
	Sta Registr		31. Date filed (Month) Day, Yaar) 8	2005 32. egist	rar's Signature	parli	J				

J		-	State of Maryland / Dep. 1- State Unpend Item 23a,pt.II,27,per me	artment of Health and N Carte of Deaths	lental Hygie	ne N2005	25037	
3 to	Physici		Decedent's Name (First, Middle, Last) Maurice Nwachukwu		2. Date of Death July 23,		3. Time of Death 11:44 A. M	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Doctors Community Hospital	4b. City, Town, or Location of Death Lanham		4c. County of Death Prince Geo		
	, Funeral Director		5. Social Security Number 5. Social Security Number 6. Sex 1 M № 2 F 7. Age (In yrs. last birthday) 49 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, You 01-11-195	9. Birth Cou	place (State or Foreign ntry) eria	
)	Aaryland f show	ō	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lite Maryland P.G. Mitch	ocation e11ville			10d. Inside City Limits 1 Yes 2 □ No	
	or 28a-	Funeral Directo	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cou	ntry?	
	a 23a	erail	10311 Sea Pines Drive 11 Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedant of Hispanic Origin? (So	acify Vos or No-	U.S.A.	can Indian	
· 9E0	iges fand 2 should be filed within 72 hours after death with the Maryland it of Health and Mental-Hygiene. If item 27 is marked other than "natural", or Itama 23a or 28a-f show or other traumatic event, it a Medical Examinate must be neitling at	þ	1 ☐ Never Married 2 1 ☑ Married 1 ☐ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 X No Specify:	Rican, etc.)	Black, White, etc. Specify: Black		
Baltimore, Maryland 21215-0036	within 72 ho ene. than "natur re Medical I	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	ident's Usual Occupation 9 kind of work done during most of work DO NOT use retired)	ring	b. Kind of Business/Ir	·	
d 21	e filed within at Hygiene. I other than 'vent, Ire Me	e Col	17. Father's Name (First, Middle, Last)	Driver 18. Mother's Nam	e (First, Middle, Ma	Self-Emplo	yea	
/lan	2 should be f and Mental, is marked of aumatic eve	To B	Francis Nwachukwu	Sarah A				
Man	i 2 should h and Men 7 is marke traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mail 10311	ing Address (Street and Number or Rui Sea Pines Drive	al Route Number, C	City or Town, State, Zi	o Code)	
. j.	Health Health tem 27		20a. Method of Disposition 20b. Place of Disp	ellville, Maryland		c. Location - City or T	own, State	
MO	Pages trand 2 nent of Health ant: if item 27 i		1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Family C	emetery 08-11	. - 05 Po	rt Hartco	urt, Nigeria	
Balti	permit. Page Depertment of Important: if any Injury or			2. Name and Address of Facility W, I				
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final				Approximate Interval Between Onset and Death	
);	Physician /Medical		disease or condition resulting in death) Hypertensive Card Due to (or as a consequence of):	iovascular Disease	9			
П	Examiner		Sequentially list conditions, if any, leading to immediate b					
40	ned Insit	Examine	Cause. Enter Underlying Cause (Disease or injury					
ó	te be executed ysicien and ie burial-transit		that initiated events resulting in death) Last					
8760,	w	edicai	d					
P.O. Box 6	Attending Physician: The law requires that the death certifica rideath. •ctor: After this certificate has been signed by the attending phorther funeral director, page 2 should be detached for use as it.	Physician/Me		□Ectopic pregnancy □ Other (<i>specify</i>)		23d. Date of deliving Month	rery Day Year	
	quires that n signed by	ρ	Part II. Other significant conditions contributing to death but not resulting in the End-Stage Renal Disease	underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?	
Records,	The law requir ate has been si page 2 should	Completed			24a. Was an autopsy performe	prior to o	opsy findings available ompletion of cause of	
Vital	lclan: T certifica rector, p	Be	25. Was case referred to medical examiner? Hospital:		th (Check only one)			
ō	ding Physin. The After this of funeral directions.	tion: To	1 Yes 2 No		ome 5 ☐ Residence 28d. Describe how	ce 6 ☐ Other (Specinjury occurred	rfy)	
Division	al or Attendi s after death. al Director: A ed in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	et and Number or Rui State)	al Route Number,	
	To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by th	Medical (29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, dea 2 ☑ Medical Examiner: On the basis of examination and/or i	nvestigation, in my opinion, death occu	rred at the time, date	and place, and due	to the cause(s)	
	With Com	M	29b. Signature and the of certifie	29c. License number OCME		I. Date signed (Month July 24, 2		
K	(5)		30. Name and address of person who completed cause of death (Item 23a) (Type	111 Penn Stree	t Baltim	ore, Mary	land 21201	
*	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	relle				

Provided Name 1				_ rut	artment of Health and Mental Hy	/giene Reg. N2 0 0 5 2 5 0 3 8
### A Country Open Holy Cross Hospital					2. Date of D	eath 3. Time of Death
Control Cases Control Case				Anna D. O'Neal	July	14, 2005 8:50A M
Some Service Municipal Company (Company Company Compan						,
The part of the					If Under 1 Year If Under 24 Hrs. 8 Date of B	irth 9 Birthplace (State or Foreign
Max. State Mo. Covery Mo.				FRO DA CAOR IDM 20XF	Months Days Hours Min. Feb. 7	1911 NC
George Dunn State Control Con		p .			contina	10d Incide City Limits
George Dunn State Control Con		Aaryla I shov	ō			12€ Yes 2 □ No
George Dunn State Control Con		the h	irect		,	10g. Citizen of What Country?
George Dunn State Control Con		th with	ai D	11432 Encore Drive	20901	United States
George Dunn State Control Con		tems	uner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
George Dunn State Control Con	36	I', or I	by F	If Yes, Give	1 ☐ Yes 2 No Specify:	Specify: Black
George Dunn State Control Con	9-0	'2 hou natura ical E			ident's Usual Occupation	
George Dunn State Control Con	21	ithin 7 ne. nen "r	npie	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	Danaman Laundau
20. Member of Disposition, Nature of Dispos	22	filed w Hygier ther ti				
20. Member of Disposition 1980 and 20. Constation - City or Town, State 20. Constant - City or Town, State 20. C	land	id be f ental l ked o'	m I			
20. Member of Disposition 1980 and 20. Constation - City or Town, State 20. Constant - City or Town, State 20. C	ary	and M		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rural Route Num.	ber, City or Town, State, Zip Code)
Secretary Committee Comm		and 2 lealth m 27 I		Gioria O Near/daughter Silv	ver Spring, Maryland	20901
23. FS.11. Enter the disease, or complications that caused the death. Do not enter the most of dying, such as cardiac or respiratory arrest. Approximate force of the death o	Jore	iges 1 or of H or ot		157 Burial 2 Cremation 3 Removal from State Cemetery, cre	matory`or other place)	
23. FS.11. Enter the disease, or complications that caused the death. Do not enter the most of dying, such as cardiac or respiratory arrest. Approximate force of the death o	Itim	artmer artmer ortant injury				
Physician Redical Examiner Aspiration Pneumonia Aspiration Pneumonia Due to (or as a consequence of):	Ba	Deprime any song			_	
Physician (Medical Examiner) The property of				23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac or respiratory	Interval Between
Due to (or as a consequence of): Due to (or as a consequence of):				Imm late Cause (Final disease or condition Pne	eumonia	Onset and Death
Sequentially list conditions. Sequentially list conditions are consequence of list and sequence of list of list and				Due to (or as a consequence or):		
Cusus of United Section (Capacity) Due to (or as a consequence of): d. Due to (or as a consequence of secuency) d. Due to (or as a consequence of secuency) d. Due to (or as a consequence of secuency) d. Due to (or as a consequence of secuency) d. Due to (or as a consequence of secuency) d. Due to (or as a consequence of s			e	Sequentially list conditions D.		
The second of the second pregnancy is a second pregnancy in the past 12 months? In least 12 months? In lea		cuted nd ransit	amir	Cause (Disease or injury that initiated events c.		
The property of the property	90,	De exe cian a purial-t	i Ex	resulting in death) Last Due to (or as a consequence of):		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus 1 Yes 2 X No 3 Probably 4 Unknown autopsy performed on cause of death?	387	physies the b	dica	d		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus 1 Yes 2 X No 3 Probably 4 Unknown autopsy performed on cause of death?	ox 6	nding use as	√Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
Diabetes Mellitus Type 2x No 3 Probably 4 Unknown 2x 2x No 2x 2x No 3 Probably 4 Unknown 2x 2x No 2x		death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No		Month Day Year
25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 5 Pending investigation 1 Yes 2 No Injury 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work?	P.0	d by the	Phy	9 Unknown	underlying cause given in Part I 23a Did	I tobacco use contribute to the cause of death?
25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 5 Pending investigation 1 Yes 2 No Injury 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work?	ds,	signe	d by	Dishahas Walliams	, g	
25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 5 Pending investigation 1 Yes 2 No Injury 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work?	cor	w requ	lete	Hypertension		s an 24b. Were autopsy findings available
25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 5 Pending investigation 1 Yes 2 No Injury 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work?	Re	The la	ome	Renal Insufficiency	per	formed? death?
1 Pes 2 No 1 Inpatient 2 XER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)	/ital		a	25. Was case referred to medical	26. Place of Death (Check only	one)
1 X Natural 2 Accident 3 Suicide 4 Homicide See Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar's Signature and States 31. Date filed (Month, Day, Year) 32. Registrar's Signature and States 33. Registrar's Signature and States 34. Registrar's Signature and States 34. Registrar's Signature and States 35. Registrar's Signature and States 35. Registrar's Signature and States 35. Registrar's Signature and States 36. Registrar's Signature 36. Registrar's Signature and States 36. Registrar's Signature 36. Registrary 36. Registra	of V	Physic this or	၉	1 ☐ Yes 2 🔀 No Hospital: 1 ☐ Inpatient 2 🔀 ER/Outpatie		
29a. Certifier (Check only one) 29b. Signature and didle of person who completed cause of death (Item 23a) (Type, Print) Dr. Dorothy Seay, 1500 Forest Glen Rd., Silver Spring, Md. 20910 31. Date filed (Month, Day, Year) 29a. Certifier (Check only one) 1		ing fter fter	tlon	27. Mainter of Death 1 XNatural 5 Pending (Month, Day Year) 1 Natural investigation		s now injury occurred
29a. Certifier (Check only one) 29b. Signature and didle of person who completed cause of death (Item 23a) (Type, Print) Dr. Dorothy Seay, 1500 Forest Glen Rd., Silver Spring, Md. 20910 31. Date filed (Month, Day, Year) 29a. Certifier (Check only one) 1	visi	Atten	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s		
30. Name and address of person who completed cause of death (tem 23a) (Type, Print) Dr. Dorothy Seay, 1500 Forest Glen Rd., Silver Spring, Md. 20910 State 31. Date filed (Month, Day, Year) 32. Registra's Signature	Ö	irs efferent Piral Dir				,,
30. Name and address of person who completed cause of death (tem 23a) (Type, Print) Dr. Dorothy Seay, 1500 Forest Glen Rd., Silver Spring, Md. 20910 State 31. Date filed (Month, Day, Year) 32. Registra's Signature		Hosp 24 hou Fune fely fil	licai	29a. Certifier 1 Certifying Physicien: To the best of my knowledge, dea 1 Medical Exeminer: On the basis of examination and/or i		
30. Name and address of person who completed cause of death (tem 23a) (Type, Print) Dr. Dorothy Seay, 1500 Forest Glen Rd., Silver Spring, Md. 20910 State 31. Date filed (Month, Day, Year) 32. Registra's Signature		vithin (Med		29c. License number	29d. Date signed (Month, Day, Year)
Dr. Dorothy Seay, 1500 Forest Glen Rd., Silver Spring, Md. 20910	}			Marath	D0053337	7/15/05
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	+	4M4				
State St. Date line (Month, Day, real) St. Registrar IIII 1 9 2005						ing, Md. 20910
				JUL 1 9 2005	,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 5 1 - For State Registrar Certificate of Death Registrar Decedent's Name (First, Middle, Last) Peter O'Brien Gerald Peter July 4a Facility Name (If not institution, give street and number) HOLY Cross Hospital 4b. City, Town, or Location of Death Silver Spring If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 088-20-3143 79 Yrs. 1**X** M 2□ F Usual Residence of Decedent 10c. City, Town or Location Beltsville 10b. County Prince George's Maryland

2. Date of Death 3. Time of Death 2005 **Physician** 7:10A. /Medical . County of Death Montgomery Examiner 8. Date of Birth (Month, Day Year) June 12, 1926 9. Birthplace (State or Foreign **Funeral** New York, N.Y Director 10d. Inside City Limits the Maryland 28a-f show ust be notified at 1 Yes 2 No Director 10f. Zip Code 20705 10g. Citizen of What Country? United States 11380 Cherry Hill Road, #304 or Iteme 23e death (Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WWII 14 Bace - American Indian. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after de Department of Health and Mental Hygiene. Important: if item 27 is marked other than "neturel", or flems any injury pother traumatic event, Ite Modical Experiment once. 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) Special Agent U.S.D.A 17. Father's Name (First, Middle, Last)

John Joseph O'Brien 18. Mother's Name (First, Middle, Maiden Sumame) Catherine Mary McNamara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11380 Cherry Hill Road, #304 Beltsville, Maryland20705 Mary E. O'Brien -wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State Metropolitan Crematory 7/20/2005 Alexandria, Virginia * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 malel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Chronic Obstructive Pulmonary Disease /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes

Reg. No.

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

1 Yes 2 No 3 Probably 4 KyUnknown

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

25. Was case referred to medical examiner? Hospital: 1 ☐ Yes 2 XNo 27. Manner of Death 1 Natural

6 ☐ Could not be

determined

28a. Date of Injury (Month, Day Year) 5 Pending investigation

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cert

2 Accident

3 Suicide

29a. Certifier

4 Homicide

29c. License number D54347 29d. Date signed (Month, Day, Year) 07-16-2005

ompleted cause of death (Item 23a) (Type, Print)

Neeraj Chopra, M.D. P.O.Box 83819 Gaithersburg, Maryland 20883

State Registrar

þ

Completed

Be

P

Certification:

Medical

us certificate has been si director, page 2 should

this

thin 24 hours a the Funerel D

within 2 To the

10

Hospital or Attending Physicien:

31. Date filed (Month, Day, Year) 2005



OBRIEN, GERALL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene O. C.

			1 - For State Registrar	State of Man	yland / Depa <i>Cei</i>	artment of He tificate of D	ealth and Iv Death		iene () () (5 25040
	Physici	an	Decedent's Name (First, Middle, La C A MILITAIR		D 4 31777 T31	THE	TDDG	2. Date of Deat	Day Y	3. Time of Death
	/Medic Examir		SAMUEL 4a. Facility Name (If not institution, gi		RANKLIN	4b. City, Town, or	IPPS Location of Death	July	26, 200	
4	Lamin	iei	3800 Salem Ch			Jarre	ttsvill	-e		Harford
	Funeral Director			Sex 7. Age (I. 1 M 2 □ F	n yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 6/11/1	Year) 9	Birthplace (State or Foreign Country) Maryland
	yland now		10a. State 10b. County	10	Oc. City, Town or Lo	cation				10d. Inside City Limits
	Man a-fsh	ctor	MD. Harf	ord		Jar	rettsvi	lle		1 ☐ Yes 2 📉 No
	or 28	Dire	10e. Street and Number		_	10f. Zip Code		10	og. Citizen of Wha	
	sath w	eral	3800 Salem C	12. Was Decedent Eve		Nas Decedent of His	21084	ocifu Voc or No.		d States American Indian,
215-0036	be tiled within 72 hours after death with the Maryland nial Hygiene. et al. Hygiene and the matural, or Items 23a or 28a-f show svent, the Marical Examiner institute mailfied at	by Funeral Director	1 Never Married Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 No	Specify:	Rican, etc.)		White, etc.
5-0	72 ho 'natur	eted	15. Decedent's E (Specify only highest gi	ducation ade completed)	16a. Deced	dent's Usual Occupa kind of work done di DO NOT use retired)	tion uring most of work	ing	16b. Kind of Busin	ness/Industry
121	within ane. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.				Mana	faatumina
d 21	filed Hygie other ent, II		17. Father's Name (First, Middle, Las				ager 18. Mother's Name	e (First, Middle, N		facturing
Maryland	should be filed within and Mental Hygiene. is marked other than aumalic svent, Ite M	To Be	Emory	Calvin	Phipps	3	Blanc	he		Baker
lary	2 should and Men is marke aumatic		19a. Informant's Name/Relationship							ate, Zip Code) 21084
	s 1 and 2 should of Health and Men item 27 is marke other traumatic		Lois W. Phipp			Salem	The second secon	service in		tsville, Md.
Baltimore,	Page: nent o ant: If i		20a. Method of Disposition 1	fy)		sition (Name of natory or other place C			20c. Location - Cit arretts	sville, Md.
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Solvice Vice	en Kinty.		E.G. Ku	rtz & S	on Fun	eral Ho	Maryland
	Physician		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition	polications that caused he one cause on each line.		er the mode of dying	, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions,	Due to (or as a c	onsequence of):	γ)	FARESCONS		
v	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a c	onsequence of):					
68760,	death certificate be executed e attending physician and nd for use as the burial-transit	fedical Ex	resulting in death) Last	Due to (or as a co	onsequence of):					
_	ertifica ling pl		IF FEMALE:	03- 16					-10	
.O. Box	that the death certied by the attending detached for use a	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of p 1 Live birth 2 [4 Pregnant at tim 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date o Month	· ·
Q	w requires that been signed by should be deta	by	Part II. Other significant conditions	contributing to death but n	not resulting in the u	nderlying cause give	n in Part I.			ite to the cause of death? Probably 4 Unknown
l Ŕecords,	e la has	Completed			-			24a. Was ar autopsy perform 1 Yes	/ prio ned? dea	re autopsy findings available in to completion of cause of th?
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?				26. Place of Deatl	h (Check only one	9)	
0,	Physi this c	7	1 Yes No		2 ER/Outpatier		4 Nursing Ho		nce 6 Other	(Specify)
Division (ding h. After fune	cation:	27. Manner of Death 1 Statural 5 Pending 2 Accident investigator 3 Suicide 6 Could not	00		Work' M 1 □ Y	? es 2 □No	28d. Describe ho		
DIV	i i ii e	Certification	4 Homicide determined		- At home, farm, str Specify)	eet, factory, office		28f. Location (Str City or Town		or Rural Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direc completely filled in by	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of n miner: On the basis of ex and manner stated	amination and/or in	occurred at the time vestigation, in my opi	e, date and place, inion, death occurr	and due to the ca red at the time, da	use(s) and manne ite and place, and	er as stated. If due to the cause(s)
)	To t To t	Σ	29b. Signature and title of certifier	-		29c. License	number 2 2 %			Month, Day, Year)
	10		30. Name and address of person who	completed cause of deat		Print)	Belon			d 2222 (1970)
	Sta Registi		31. Date filed (Month, Day, Year)	32. Faistrar's		inte	- 01	1		
				1-001	- 1					

:50 AM

			For	State of Ma	ryland / [lental Hy	giene	Э	
			1 - State Registrar			Cen	tificate of L	Death	2 Pata of Da	Reg. No	2005	25041
	Physici /Medio		1. Decedent's Name (First, Middle, Las Anne Hyd		cane	$P\epsilon$	eke		July 2		.005 Yeer	5:40 P. M
	Examir		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of Death			. County of Deat	
	7		22680 Cedar Lane 5. Social Security Number 6. S			-db-da()	Leonardt	OWN If Under 24 Hrs.	S Date of Bir	_	t. Mary	
6	Funeral Director		577-16-0787		(In yrs. last bir	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da July 2	v. Year	17 Sout	hplece (State or Foreign untry) th Carolina
	land wo		Usuat Residence of Decedent 10a. State 10b. County		10c. City, Tow	m or Loc	ation					10d. Inside City Limits
	Mary a-f eh	tor	Maryland St. Mary	y's	Leonar	dtow	m					1 ☐ Yes 2√7 No
	h the	Director	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What Co	untry?
	th wil		22680 Cedar Lane	Ct. #1206			20650			Uni	ted Stat	tes
36	d within 72 hours after death with the Maryland piene. If then "natural", or Items 23a or 28a-f ehow the Marical Examiner must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give — Year or Dates:		If	/as Decedent of Hi Yes, specify Cubar ☐ Yes 2√ No	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecfy Yes or No Rican, etc.)	-	14. Race - Ame Black, While Specify: W	
21215-0036	na -	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)		(Give k	ent's Usual Occupa ind of work done of O NOT use retired,	luring most of worki	ng	16b. K	(ind of Business/I	Industry
212	filed within I Hygiene. other then I rent, Ite Mac	omb	Elementary/Secondary (0-12)	College (1-4or 5-		each	ner			Pub	lic Scho	ools
	othe	BeC	17. Father's Name (First, Middle, Last)					18. Mother's Name			Sumame)	
ylai	should by and Menta	To	John Edward Walk					Harriet				
Maryland	12 should he and Months and Months is mark		19a. Informant's Name/Relationship (1		1			nd Number or Rura				(ip Code)
	s 1 and 2 of Health Item 27 i		Elizabeth P. Mil	ler (Daug	20b. Place of	Dispos	ition (Name of		ate		ocation - City or 1	Town, Slate
altimore,	Page ment o ent: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	cemeter	ry.crem olit	atory or other place an Crema	tory 2005				, Virginia
Bal	permit. Depart Import any inj		21. Signalure of Funeral Service Licen	Villden								ation Servic s, MD 21401
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each tine	he death. Do n			s, such as cardiac o		rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in dealh)	Due to (or as a	consequence	of):					1	7.
	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence	of):						
30,	cate be executed physician and the burial-transit	i Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence	of):						
8760,	physic the b	dicai		d								
.O. Box 6	that the death certific ed by the attending p detached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ ∀ss 2 No 9 □ Unknown	23c. If yes, outcome of □Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetel death		Ectopic pregnancy Other (specify)				23d. Date of delin Month	very Day Year
۵.	es that thighed by be detact	by Pl	Part II. Other significant conditions of	ontributing to death bu	not resulting in	n the und	derlying cause give	n in Part I.	23e. Did t	obacco i	use contribute to	the cause of death?
ırd	v require been sig should b	ted t							101	es 2	XNo 3□Pro	obably 4 Unknown
Vital Records,	e lav has je 2	Completed							24a. Was autop perfo		prior to o	opsy findings available ompletion of cause of
ital	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?					26. Place of Death				
of V	Physician: this certific ral director.	ို	1 ☐ Yes 2 No	Hospital: 1 Inpatien			3□ DOA Othe	4 Nursing Hon				ify)
UC C	ding F	ion:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day		rime of	28c. Injury Work	at ? ′es 2 □No	8d. Describe t	ow injui	ry occurred	
Division	I or Attending after death. Director: Afte I in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		y - At home, fa (Specify)	rm, stree		-	28f. Location (S City or Tox			ral Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical Ce	(Check only 2 Medical Exam	ysician: To the best of iner: On the basis of e	xamination and							
\	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner state			29c. License	number		29d. Dai	te signed (Month)	Day, Year)
-			30 Name and address of access with	completed cause of do	ath (Item 23a) /	Tyne P	rint)	110		/-	11-0	
	()		30. Name and address of person who of Journ Scott Ti DBA Co. 31. Date filed (Month, Day, Year)	MD 26	54W11	dea	wood Cen	196 40R, CEI	HORM.	A. 1.	ND 20	0619
	Sta Registr	_		005	J. B.	60	and					
			LICA VILL	1.00.00.00								

			For State Registrar	State of Maryla	•	artment of Hertificate of E			ene 005	25042
	Physici	an	1. Decedent's Name (First, Middle, La Iola Lill	· ·				2. Date of Death Month	Day Yea	3. Time of Death
	/Medic	al	4a. Eqcility Name (If not institution, given			4b. City, Town, or,	Location of Death	-July	4c. County of De	
	Examili	iei	Prince Ceorge				erely		Prince	6 eorge's
	Funeral Director		577-09-5861	Sex 7. Age (In yi	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H/s. Hours Min.	8. Date of Birth (Month, Day, 1 11/24/19	rear)	lirthplace (State or Foreign Country) ryland
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	a-f sh	ctor	DC		Washing	rton				Yes 2 No
	vith the	Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
	ns 23e	eral	136 - 53rd Stree	12. Was Decedent Ever in		20019 Was Decedent of His	spanic Origin? (Spe	ecify Yes or No-	U.S.A.	nerican Indian,
980	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If itam 27 is marked other than "natural", or Itams 23a or 28a-f show or other traumatic event, the Modical Exa	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		f Yes, specify Cubar 1 ☐ Yes 2 XX No	Specify:	Rican, etc.)	Specify: B	
21215-0036	72 ho	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	tent's Usual Occupa kind of work done de	urina most of worki	ing 16	6b. Kind of Busines	s/Industry
121	within ene. than	Jumo	Elementary/Secondary (0-12)	College (1-4or 5+)	Prin	00 NOT use retired) ter			Federal	Government
	e filed Il Hygi other vant, I	Be Co	12th 17. Father's Name (First, Middle, Las)	1 2 2 2 1		18. Mother's Name	e (First, Middle, Ma		GOV CITINGITE
ylar	should be and Mental markad o	ToE	John Fountain					e Carter		
Maryland	d 2 sho th and 7 is ma trauma		19a. Informant's Name/Relationship Elijah Powell, Ja	** *		ng Address <i>(Street al</i> 3 rd Stree				, Zip Code) 20019
	of Health itam 27 r othar tr		20a. Method of Disposition	206	. Place of Dispo			-	c. Location - City	
altimore,	Page Iment c tant: If jury or		1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	(y) C		lls Cemet		5/2005 S	Suitland,	MD
Bal	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or othar once.		21. Signal of Funeral Service Lice	RODNAM -) P	.O.Box 416;	Suitland,	Maryland 2		
L			23a. Part 1. Enter the disease, or con shock of heart failure. List on	one cause on each line.	eath. Do not ent	er the mode of dying	, such as cardiac c	or respiratory arres	t,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Lue to (or as a cons		TrTZ	41054-	erolec	Hear	Onset and Death
r	Examiner .		Commentation line and distance	b	equerice orj.					
	ed sit	lner	Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):					
,	execut n and ial-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a cons	equence of):					
8760,	icate be executed physician and s the burial-transit	dlcall		d						
9		/Med	IF FEMALE:	23c. If yes, outcome of pred	gnancy				23d. Date of o	elivery
.O. Box	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₩ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
<u>α</u>	res that tigned by	by	Part II. Dther significant conditions	contributing to death but not r	esulting in the ur	nderlying cause give	n in Part I.			to the cause of death?
Records,	w requir been si should	eted						24a. Was an		autopsy findings available
	sician: The law certificate has b irector, page 2 s	Completed						autopsy performe	prior to death	completion of cause of
Vital		Bec	25. Was case referred to medical examiner?				26. Place of Death			
of	Phy r this	2	1 Yes 2 No 27. May of Death	Hospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Other	4 Nursing Hor	ne 5 Residence 28d. Describe how	ce 6 ☐Other (Sp	ecify)
on	nding Ph ath. r: After th e funeral	atlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)		Work*			,,	
Division	I or Attandi after death Director: A in by the f	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, streety)	eet, factory, office	4	28f. Location (Stre City or Town,		Rural Route Number,
	To the Hospital or Attanding within 24 hours after death. To tha Funaral Director: After completely filled in by the fune	edical C		nysician: To the best of my k miner: On the basis of exami and manner stated.						
	To the within 2 To tha complet	Me	29b. Signature and title of certifier	10 0		29c. License	number	290	. Date signed (Mo	nth, Day, Year)
Ł	-		1 Sahadu	1 Alost	, Dre	= 14	00558	27 J	uly 11,	2005
+	1/6		30. Name and address of person who	completed cause of death (It	/	Print) Drive	che:	ry 1	my lan	d
	Sta Registr		31. Date filed (Month, Day, Year) JUL 1 9 2005	32. Registrar's Sig	nature	,		0)		

			1 = For State Registrar	State of N	Maryland / Depa Cei	artment of H rtificate of L			ene .2005	25043
	Physici /Medic		1. Decedent's Name (First, Middle, Last, Janes A Par	kins				2. Date of Death Month	Day Year	3. Time of Death
	Examir		4a. Facility Name (If not institution, give University of M		medical Center		timore	4	4c. County of Dea	th
	Funeral Director		230-20-7087	M 2□F	Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 4	Year) Co	thplace (State or Foreign ountry) ginia
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County Maryland Caroline		10c. City, Town or Lo					10d. Inside City Limits 1. Yes 2 ☐ No
	with the file or 28a-	Director	10e. Street and Number		Riuge	10f. Zip Code	.660	10	g. Citizen of What Co	ountry?
36	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-1 show Alfral Expendent outs to confided at	by Funeral	24009 Holsinger 11. Marital Status 1 □ Never Married 2. Married 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 Deceder 1 Deceder 1 Fes, Give Year or Dates	No	Was Decedent of Hi If Yes, specify Cubar		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
21215-0036	within ane. than	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i> College (1-4o	(Give life.	dent's Usual Occupa kind of work done d DO NOT use retired,	luring most of work	U	6b. Kind of Business niversity	
Maryland 2		To Be C	17. Father's Name (First, Middle, Last) Fount Thomas	Perkins			18. Mother's Nam	e (First, Middle, M ice Penn	aiden Sumame)	
	nd 2 shu lith and 27 is m r traum		19a. Informant's Name/Relationship (Ty Marie Perkins /	_{рө, Print)} Wife					City or Town, State, . Maryland 2	
Baltimore,	Pages 1 au nent of Hea int: If itam iry or otha		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	temoval from Stat	te	sition (Name of matory or other place	9)		oc. Location - City or or or 10ck, Mai	
Balti	permit. Pages Department of I Important: If ite any injury or of		21. Signature of Funeral Service Licens	Knis	$\frac{22}{2}$	R. Name and Addres Bennie Smi 126 Dover	s of Facility th Funer Street, E	al Home aston,Ma	ryland 216	
	Physician /Medical		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each	line.			or respiratory arre	st,	Approximate Interval Between Onset and Death 2 weks
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last	Due to (or a	as a consequence of): actor 8 in h as a consequence of): as a consequence of):	isliter d	Sease			2 weeks
.O. Box 68	The law requires that the death certificate has been signed by the attending places 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)			23d. Date of de Month	ivery Day Year
Δ.	quires that n signed by	by	Part II. Other significant conditions con	ntributing to death	but not resulting in the u	nderlying cause give	on in Part I.		acco use contribute to	o the cause of death?
Records,		Completed						24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		othe Othe		h (Check only one		_
of	ng Phys fter this neral di	ition: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, L	njury 28b. Time of	28c. Injury Work	4 Nuising H	ome 5 ☐ Resider 28d. Describe how	nce 6 Other (Spe v injury occurred	cify)
Division	F # F C	Certification:	3 Suicide 6 Could not be determined	28e. Place of building,	Injury - At home, farm, str etc. (Specify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ri State)	ural Route Number,
	To the Hospital or At within 24 hours after or To the Funaral Dirac completely filled in by	edical (st of my knowledge, deatl of examination and/or in stated.					
	Tot withi Tot	Ň	29b. Signature and title of certifier	MT)	PIS	-		d. Date signed (Mont	h, Day, Year)
K	5-100		30. Name and address of person who co	ene 5 h	f death (Item 23a) (Type,					
	Sta Registi	ite	31. Date filed (MONT), 039, Year 2005	32. Regis	strar's Signature	Print) More, M	7,00	•		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2 0 0 5 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 18 Joseph A. Pallotto July 2005 /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Gilchrist Hospice Towson If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Apr 26, 1929 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1**X** M 2□ F Yrs. 177 22 2975 76 Pennsylvania Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location *show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo **Funerai Director** MD Howard Ellicott City 28a-f 10g. Citizen of What Country? 10e, Street and Number Itams 23a or 9199 Furrow Avenue 21042 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1XYes 2 No If Yes, Give Year or Dates:1948-52 1 Never Married Married 5 Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: à 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Printer Printing other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) to and 2 should be fill Health and Mental Health and Mental Health are 27 is marked oth Peter L. Pallotto Florence L. Matoney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health a ltem 27 is other tra Denise A. Chairs/Daughter 9199 Furrow Avenue Ellicott City, MD 21042 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 0 = 0 1 | Burial 2 | Cremation 3 | Removal from State | Crest Lawn Mem. Gard. 7-21-2005 | Marriottsville, MD Department of Important: If any injury or 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) week Strong Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine nding physician and use as the burial-transit Due to (or as a consequence of): Physician/Medicai use as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 4☐Pregnant at time of death signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 3 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy certificate 1□ Yes 2[of Vital Physiclan: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Wither (Specify 10) 01 00 ဂ္ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Certification: After Injury 5 Pending 1 Estatural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 T Homicide To the Hospital or within 24 hours a To the Funeral I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier person who completed cause of death (Item 23a) (Type, Print) nerses S 66 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State Melle Registrar

Pallotto

loseph

		1 - For State Registrar	State of	f Maryland		rtment of F	lealth and <i>Death</i>	Mental H	ygiene Reg. N. (105	250	1, 5
		Decedent's Name (First, Middle	e, Last)			-		2. Date of I		Your	3. Time of	Death
	sician	ANNA	P	EARL	I	RUTHERI	FORD	July	26,	2005	7:36	AM
	edical miner	. E- We Non- Minate in all all	n, give street and nur	nber)		4b. City, Town, o	or Location of Dea	th	4c. Co	ounty of Death		
Exa		Upper Chesan	eake Me	dical	Center	r I	Bel Air			Harf	ord	
Fune	ral	5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	B. Date of E	Birth Da <i>y, Year)</i>	9. Birth	place (State o	or Foreign
Direct		218-38-3468	1□M 2 X F	83	Yrs.	Inorana Baya	1100.0	1/15	/1922	2 Ma	rylan	ıd
р ,		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Loca	ation					10d. Inside Ci	ity Limits
Maryland -f show	,			Too. Oily	, 10#11 01 LOC		TT	222				2 X No
8a-f	cto	MD. Ha	rford				rest H	111	10- 02-	en of What Cou		
ith th	Director	10e. Street and Number				10f. Zip Code	03.050					
death with the ms 23e or 28a	2	1434 Shar			C 12 M	Inc Decedest of I	21050			ted St		
er de Item	Funeral	1 11. Marital Status 1 □ Never Married 2 □ Mar	Armed Fo	edent Ever in U.: rces?	3. 13. VV	Yes, specify Cub	Hispanic Origin? (an, Mexican, Pue	rto Rican, etc.)	100	Black, White		
rs aft	3			/e	1	☐ Yes 2 X No	Specify:		S	pecify:	White	3
Z.15-UU36 thin 72 hours after death with the Marylar e "natural", or Items 23e or 28e-1 show Matural Frame er marker colling 4	0	15. Deceder	nt's Education		16a. Decede	ent's Usual Occu	pation		16b. Kind	d of Business/Ir	ndustry	
C Z uin Z	i i	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1-4or 5+)	(Give k life. D	ind of work dorie O NOT use retire	during most of world)	orking				
d 2127 filed within Hygiene. ther then "	Completed	1	O	1 401 317		Housev	wife			Home	;	
other other	98	17. Father's Name (First, Middle	Last)				18. Mother's Na	ime (First, Midd	fle, Maiden Si	umame)		
land be Alental Alental rked of the say of t	2	James	Edwar	d.	Grove	r	Franc	ina	May	Gc	rdon	
Maryland d 2 should be file th and Mental Hy 7 Is marked oth		19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailing	Adriess (Street	and Number or F	lural Route Nun	ber, City or 1	Town, State, Zi	ip Code) 2]	221
_ c = 0 r		Stella L. Mi	Lhavets/				rside D			timore)
of Healt		20a. Method of Disposition 1 Burial 2 □ Cremation	2 Demoval from		lace of Dispos emetery, crem	ition (Name of atory or other pla	ice)	Date	20c. Loca	ation - City or T	'own, State	
Pages ment of ant: If it		4 □ Donation 5 □ Other (Bel Ai	r Mem	. Garde	ens 7/2	9/2005	Bel	Air.	Maryl	and
프트로운영		21. Signature of Euneral Service	License	111	11 22.	Name and Addre	ess of Facility J	arrett	svil]	Le, Ma	rylar	ıd
	8000	11/ Bles	clown 1	150/3-			irtz &			L Home	. P.A	
		23a. Part1. Enter the disease, of shock, or heart failure. Lis									Approximat Interval Bet	tween
Pnysici	ள்	Immediate Cause (Final disease or condition	a	cute	144	DCAR	DIAC	INF	ARC	TOOK	Onset and	Death
/Medio	cal	resulting in death)	a. Due to	(or as a consequ	uence of):		DIAC	0.0			13. 4. 0	-
Examir	ner	Conventially list conditions	. 15	CHE	MIC	140	ant	11050	ase		1 car	C
7	à	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequ	uence of):	and	Cr2850	Land			4000	20
outec	Tanima y	Cause (Disease or injury that initiated events	U			Wig	C - 597 C	-1000	362		1 CACLE	3
60, be executed sician and burial-transit			Due to	(or as a consequ	uence of):							
a 2 3	9 5		d									
Box 68 leath certifica	Na Ma	IF FEMALE:										
that the death cert ed by the attendin		23b. Was decedent pregnant in the past 12 months?	1 Live I	tcome of pregna birth 2 □ Feta	Ideath 3□	Ectopic pregnanc	су		23	3d. Date of deli- Month	,	Year
9 dea he at		1 Yes 2 No	4□Pregr 9□Unkn	nant at time of di	eath 5□	Other (specify) _			- 1		,	
P.O lat the d by th	טאיל	9 Unknown		lanth hut not roo	ulting in the up	darbijas pausa s	was in Bost I	23a Di	d tobacco use	e contribute to	the cause of	death?
S, F		Pair II. Other significant control	ions contributing to d	. My o/	// Les	errying cause g	Venin Faiti,		Tes 2	c	obably 4	
cord w require been sli		100	2 -	4								
Peco	2	1450	peder	med				24a. W	as an topsy	24b. Were aut	topsy findings completion of a	available cause of
The The	page s stored							1 ☐ Yes	normed? 2 No	death? 1 ☐ Yes	2□ No	
Division of Vital Records, to Attending Physician: The law requires tafter death. Director: After this certificate has been signed to the physicial physicial physicials.	Ciol.	25. Was case referred to medic	T. C. C. C.					eath (Check on				
hysic his c		1 ☐ Yes 2 No		-	ER/Outpatient		ther: 4 Nursing				ufy)	
ng P		27. Manner of Death 1 Natural 5 Pend	ing 28a. Date	of Injury oth, Day Year)	28b. Time of Injury		ork?	28d. Describ	e how injury	occurred		
ision kttendir death. ctor: A		2 Accident inves	tigation]Yes 2 □No		10:		10 11	
Division of or Attending Physafter death. Director: After this	60		mined 286, Place	e of Injury - At ho ling, etc. <i>(Specif</i>	ome, farm, stre y)	et, factory, office			n (Street and Fown, State)	Number or Ru	rai Houte Nun	nber,
Ital o												
Div To the Hospital or A within 24 hours after To the Funeral Direct	completely filled in by the furiel as unlector, page	(Check only 2 Medica	ing Physician: To the I Examiner: On the b	pasis of examina								(s)
the hin 2	neidu			nner stated.		20a Licos	ise number		29d Date	signed (Month	n Day Yearl	
T V	00	29b. Signature and title of certif	00.4	1-1		250. Licer	17679	,	2.50. Date	1-11	0.3	
		Hours		- (-//	¥	11	100/		1	1201	-5111	72
Ц		30. Name and address of person AGATON H. 5	n who completed cau	se of death (Item	n 23a) (Type, f	Print)	MICHALL	ERR	JAR	VICE 1	12 201	
1		AGATON H. G	SALARO	Anistraria Giana	77. 36	A	100-100		M	d Ll	0 84	
Po	State pistra	AUG (1 2005	Alux.	J. A	medi						

Rutherford, Anna

			1 - State of Maryland / D	Department of Health and None Certificate of Death	Mental Hygie	
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year
ı	Physicia /Medic		Nataniel Antonio Salas Reye	s		15 2005 11:44PM ^M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Holy Cross Hospital	Silver Spring		Montgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bird	thday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yo	
	Director	}	none 33 Usual Residence of Decedent	115.	06/18/7	2 Republic
	and	ł	10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
	Mary f sh	ō	NC Hope Mills Cumbe	erland		1 X Yes 2 □ No
	the	Director	10e. Street and Number	10f. Zip Code	10g	Citizen of What Country?
	n with	Die	6429 Bretton Wood Drive	28348	Do	ominican Republic
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.
ဖွ	after or Ite		1 Never Married 2 Married 1 Yes 2XNo	1 ☐ Yes 2 ☐ No Specify:	, , , , , , ,	Specify: Black
8	be filed within 72 hours after death with the Maryland tal Hygiene. Id Hygiene "natural", or Items 23a or 28a-f show of other than "natural", or Items 23a or 28a-f show event, the Medical Exactinat retail the rediffied at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			
2	"nati	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NDT use retired)	ing 16	b. Kind of Business/Industry
Maryland 21215-0036	withir ane. than	d m	Elementary/Secondary (0-12) College (1-4or 5+)			1
2	filed Hygi ther ant, t	Ö	1.7. Father's Name (First, Middle, Last)	nknown 18. Mother's Nam	e (First, Middle, Ma	Unknown iden Sumame)
an	d be ental ked c	To Be	Dafael A Cales	11412	7 Domes	
2	shoul nd M mari	۳	Rafael A Salas 19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street and Number or Run	A. Reyes	
	nd 2 alth a 27 is		Hilda Reyes Mother 64	129 Bretton Wood	Drive Ho	pe Mills, NC28348
ē,	es 1 and 2 should be fi of Health and Mental F fitem 27 Is marked ot r other traumatic ever		cemeter	orematon, or other place)		c. Location - City or Town, State
Ë	Page nent c int: If		1 Burial 2 Cremation 3 Hemoval from State	dale Crematory	/19/05 _R	iverdale, MD
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Snature of Funeral/Service Licensee	22 Name and Address of Easily		Street NE
<u> </u>	89 E 29		part holecon	Dunn and Sons F	uneral H	ome Washington, DC
			23a. Part. Enter the disease, or complications that caused the death. Do report, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arrest	Approximate Interval Between Onset and Death
	Pnysician		Immodiate Cause (Final disease or conditiona_Diabetic Ket	oacidosis		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of			
ĸ	Lxammo	<u>_</u>	Sequentially list conditions, if any leading to immediate b. Sepsis Due to (or as a consequence or	off.		
	led nsit	nine	cause. Enter Underlying Cause (Disease or injury	J		
_6	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of	of):		
8760,	rate be executed thy sician and the burial-transit	dicai E				
89	ifficate t g physical as the b					
Вох	death certifica e attending pla d for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of delivery
		sicla	in the past 12 months? 1 Yes 2 No 9 Unknown	5 Other (specify)		Month Day Year
О. О.	The law requires that the de ate has been signed by the a page 2 should be detached	hys	9 Unknown			
Ś	es tha igned be del	by	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.		cco use contribute to the cause of death?
ord	w require been sig should b	ted			1 1 105	2 No 3 Probably 4 ∰Inknown
ec	has by	ple			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u>=</u>		Completed			performe	d? death? No 1 ☐ Yes 2 ☐ No
/ita	ician: Th certificate rector, pag	Be	25. Was case reterred to medical examiner?		th (Check only one)	
Division of Vital Record	hys this	To I	1 Tes 2 K No 1 Linpatient 2 EH/Ou	tpatient 3 DOA 4 Nursing Ho	ome 5 Residence 28d. Describe how	e 6 Other (Specify)
U	fing After fune	tion	1 XNatural 5 ☐ Pending (Month, Day Year)	njury Work? M 1 ☐ Yes 2 ☐ No	200.000.00	injury cocamou
18	2 0 2	fica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, fa			et and Number or Rural Route Number,
<u> </u>	Dit o	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, S	State)
	To the Hospital or within 24 hours afte To the Funeral Dircompletely filled in 1		29a. Certifier 15 Certifying Physicien: To the best of my knowledge			
	he Ho in 24 he Fu pletel	edicai	(Check only one) 2 Medical Exeminer: On the basis of examination an and manner stated.	dor investigation, in my opinion, death occur	red at the time, date	and place, and due to the cause(s)
	To the P within 2 To the F complete	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
l			> Uny Nixola	D0062885	Ju	11y 18, 2005
M	3		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)		
J .			Sonja C Wyche 1500 Forest	Glen Road Silver	Spring M	ID 20910
	Sta Registr		31. Date filed (Month, Day, Year) JUL 1 9 2005	mele		
	,5		17			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) Month Dav **Physician** Radcliff July 15, 2005 2:40 a McConchie Marjorie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Montgomery General Hospital Olney If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2**x**□ F Yrs. Director June 6, 1920 <u>Virginia</u> 577<u>18 5763</u> Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hyglene. Important: If item 27 Is marked other than "naturat", or Items 23a or 28a-f show my jury or other traumatic event, the Medical Examinat Expeditional once. 1 ☐ Yes 2 No Director Maryland | Silver Spring Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20906 USA 15026 Haselmere Court by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐Yes 2 Yes, Give 1 Never Married 2 Married 2 No 1□Yes 2HNo Baltimore, Maryland 21215-0036 Specify: White 3 ☐ Widowed 4 ♣ Divorced If Yes, Give Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Annie Elizabeth Wilkins Byrd Powell McConchie ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18500 oxfordshire Terrace Olney, Maryland 20832 Sterling W. Radcliff, Jr. / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cemeteyr 7/19/05 | Silver Spring, Maryland 22. Name and Address of Facility Hines Rinaldi Funeral Home 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease of mailtion resulting in death) Physician con a /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760 ician/Medical the IF FEMALE: 980 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Yes 2 No P.0. the Physic 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Tyes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 110 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check on one Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ို completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide within 24 hours a To the Funeral C (Destifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 2005 ddress of person who completed cause of death (Item 23a) (Type, Print) 2901 Olney-Sandy Spring Rd; Olney, MD 20832 Lodmell M.D. John G. 31. Date filed (Month, Da 32 Registrar's Signature Day, Year) State 2005 Registrar

		110400	State of Manua	nd / Don	admost of H	oalth and	d Montal	Hygion	0	
		1 _ For State	State of Maryla		artment of Fi rtificate of L		Jivientai		7111	2501.0
		Registrar 1. Decedent's Name (First, Middle, Last	2	CE	rincate or L	Jeani	2 Date	Reg. No	0.6000	3. Time of Death
Physic /Medi			e RICHAI	PDSO	N		Tu!	h Da	Year ZCC	0
Exami		4a. Facility Name (If not institution, give	1 .	0	4b. City, Town, or				. County of Dea	
		DEERS HEAD	HOSPITAL				nRy		WICO	
Funeral Director		5. Social Security Number 6. Se 1[х ⊐м 2Д б 7. Age (In yn	s. last birthday) Yrs.	Months Days	Hours N	lin. Bec	of Birth th, Day, Year • 29 1	931 F1	thplace (State or Foreign ountry) orida
D >		Usual Residence of Decedent 10a. State 10b. County	100 /	City, Town or Lo	posting					10d. Inside City Limits
anyla ahov	2									1 2 Yes 2 □ No
the M	Director	Maryland Dorches 10e. Street and Number	ter l	east New	W Market			10g C	itizen of What Co	puntry?
with a or i	급				,	1		g. 0	USA	,
Jeeth ns 23	Funeral	5918 Harvey S	12. Was Decedent Ever in	U.S. 13.	Was Decedent of Hi	spanic Origin?	(Specify Yes	or No-	14. Race - Ame	
or Iter	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 12 No		If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	n, Mexican, Pu Specify:	uerto Hican, et	c.)	Black, Whi	te, etc.
ours a	d by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		165 2,410	Зреспу.				Black
72 h	Completed	15. Decedent's Ed (Specify only highest grad		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	turing most of	working	16b.	Kind of Business	/Industry
within the same of	mp	Elementary/Secondary (0-12)	College (1-4or 5+) 2		House Kee	,		Ne	w Begin	nings
be filed within 72 hours after deeth with the Maryland tal hygiene. Idea hygiene. In the matural, or Items 23a or 28a-f ahow event, the Medical Examinational bunctified at		17. Father's Name (First, Middle, Last)			ilouse kee		Name (First, M			
id be ental ked o	To Be	Joe Rose				Li1	ler '	Thomps	on	
all y all within 2.12. 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Manal aumatic event, the Manal aumatic event.	-	19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ing Address (Street a			Vumber, City	or Town, State,	Zip Code)
		Morris Gilmore /	Son	56 R	yan Dr., (Cameron	1,N.C.	28326		
of He cothe		20a. Method of Disposition 1 D Burial 2 Cremation 3		. Place of Dispo cemetery, cre	osition (Name of matory or other place	e)	Date		_ocation - City or	
mil. Pages pertment of I portant: If its y injury or o		4 □ Donation 5 □ Other (Specify)	Md. Ve	terans Ce	m. 07-	-26-200	5 Hu	rlock,M	aryland
permit. Pages 1 and 2 should Department. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic page.		21. Signature of Funeral Service Licen:	0 /	2	2. Name and Addres Bennie Sm:	s of Facility ith Fur	neral_H	ome	1	1 01610
		23a, Part 1. Enter the disease, or comp	mal		516 S, Ma			-	Marylan	d Z1613 Approximate
		shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.					-		Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. END 575 Due to (or as a cons	equence of:	MEIL,	2/36	+36			YRS
Examiner			DIABE	7-6-5	ME/11	7215	-2			2,23
	jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons							0
cuted nd ransit	Examiner	that initiated events	C							
ate be executed sysician and he burial-transit		resulting in death) Last	Due to (or as a cons	equence of):						
oord ificate b g physic as the b	dical		d							
OX O	/Me	IF FEMALE:	23c. If yes, outcome of pred	nancy					23d. Date of de	disease
eath dath	cian	in the past 12 months?	1 Live birth 2 □ Fe 4 □ Pregnant at time o	etal death 3	□Ectopic pregnancy □ Other (specify)				Month	Day Year
the d	Physician/Med	1 ☐ Yes 2 M No 9 ☐ Unknown	9□ Unknown							
Vital neconus, F.O. DOX 00 of initian: The law requires that the death certificate I certificate has been signed by the attending physicator, page 2 should be detached for use as the I	by PI	Part II. Other significant conditions co				en in Part I.	23e.	Did tobacco	use contribute t	o the cause of death?
equire equire en sig	ed	CONGESTIVE	e HEART	1-A	LURE		_	1 Yes	2 /2 No 3□P	robably 4 Unknown
law requires the second	Completed						24a.	Was an autopsy	24b. Were a	utopsy findings available completion of cause of
The The Sate has page	Com						1 🗆	performed?	death?	s 2 No
ysician: Tysician: Tysician: Sertificat	Be (25. Was case referred to medical examiner?	11		0.1		Death (Check	only one)		
<u>_ × ∞ ō</u>	2	1 ☐ Yes 2 🔀 No 27. Manner of Death		ER/Outpatie		4 pe inursii		Residence	6 □Other (Spe	ecity)
e fe e	tion	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)		Worl	k? Yes 2 □ No	200. 200	choo now in	ary occurred	
or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injury - Al	home, farm, st						lural Route Number.
ef or safter saf	Certification:	4 Homicide	building, etc. (Spe	icity)			City	or Town, Sta	10)	
To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (ysician: To the best of my liner: On the basis of exam and manner stated.							
o the athin o the omple	Med	29b. Signature and title of certifier	wing married stated.		29c. License	e number		29d. D	ate signed (Mon	th, Day, Year)
F 3 F 8		N. DIC	0	Unda		339	25	_7	u/0/	9.2005
		30. Name and address of person who	completed cause of peath(I	-	. Print)		-	A .		
2		VIRGINIA D	ulary m	Den	D Po	13012	-012	2A/15	Dury	9,2005 hd 21802
	ate	31. Date filed (Month, Day, Year) 2 2 2005	32. Registrar's Sig	nature	La-				,	
Regis	traf	A 4 F 14 . EAAD		100 Page 100						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) Month JULY Day 15 **Physician** 2005 5:00PM M ROBERT S. RUSS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner TALBOT 10587 KITTY'S CORNER ROAD CORDOVA If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, JAN 10 7. Age (In yrs. last birthday) 5 Social Security Number 9. Birthplace (State or Foreign **Funeral** 1**X**M 2□F Months 72 MARYLAND Director 220-26-1297 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show itam 27 is markad other than "natural", or itams 23a or 28a-f shov other traumatic event, the Madical Examinar in ust be notified at 1 ☐ Yes X☐ No Director MD TALBOT CORDOVA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10587 KITTY'S CORNER RD. 21625 AZU death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 2 should ba filed within 72 hours after on and Mental Hygiene. Is marked other than "natural, or Itar 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FARMER AGRICULTURE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JAMES S. RUSS ဂ္ SARA WHITELEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pagas 1 and 2 st Department of Health and Important: If Itam 27 Ia n any injury or other traun <u>once.</u> REGINA G. RUSS/WIFE 10587 KITTY'S CORNER RD, CORDOVA, MD 21625 20a. Method of Disposition

1 Aburial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 7-20-2005 EASTON, MARYLAND SPRING HILL CEMETERY 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST EASTON, MD 21601 21. Signature of Funeral Service Licensee JOHO R. MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DISEASE PARKINSON'S Pnysician Years disease or condition resulting in death) /Medical Examiner OROPHARYNG EAL Years DYSPHAGIA Sequentially list conditions, it any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate ba executad the attending physician and hed for use as the burial-transi Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signad by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ ed bluods 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home MResidence 6 Other (Specify) Hospital: 1 □ Yes 2 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this er of Death 28a. Date of Injury (Month, Day Year) 28c 28d. Describe how injury occurred Certification: After 1 Natura 2 Accident Hospital or Attanding 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Diractor: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 29a, Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated tha 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ertifier 2 118/05 D0057067 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUKERE MO, 667 DUTCHMANS LANE, EASTON MO 21601 DAMIAN Year) 9 strar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registre Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 23, 2005 Year **Physician** 5:02A MARGARET RUTH SWIGGARD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Civista Medical Center LaPlata Charles If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 M 20 Yrs. MAY 6,1926 Director 578-28-0560 79 WASH., DC Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f show other traumatic event, the Medical Exeminer quality notified at Director 1 ☐ Yes 2 ☐ No MARYLAND CHARLES PORT TOBACCO 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20677 238 9965 POOR HOUSE RD. Funeral items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 2 X No 1 Never Married 3 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2X No Specify: Specify: ģ WHITE 3 Widowed 4 Divorced natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7: th and Mental Hygiene. 7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 10 OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be EMILEY DAWSON ဂ FRANK HILTZ19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health Important: if item 27 RALPH F. SWIGGARD-HUSBAND 9965 POOR HOUSE RD., PORT TOBACCO, MD 20677 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □Donation 5 □ Other (Specify) MEMORIAL GARDENS 7-27-05 WALDORF, MARYLAND TRINITY 21. Signature of Euneral Service Licensee 22. Name and Address of Facility M00479 RAYMOND FUNERAL SERVICE, P.A. 23a. Pant . Enter the disease, or complications that caused the death. Do not enter the mount by sudiffer the process of the p Approximate Interval Between Onset and Reath Immediate Cause (Final disease or condition resulting in death) **Physician** JIELECTASIC 0 AWILL /Medical Due to (or as a consequence of): Examiner MOTORA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The taw requires that the death certificate be executed physician and s the burial-transit HTDXII TREDRICKS. Due to (or as a consequence of) Box 68760. Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No certificate 1 Tyes 1 Yes 2 No Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No ŏ this Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification; After Division Hospital or Attending 5 Pending Natural 1 ☐ Yes 2 ☐ No death. investigation ☐ Accident Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [Image: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a, Certifier (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D20629 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George H Wathen, MD 11345 Pembrooke Sq Ste 103 Waldorf, MD 20603 6 AUG 0 1 2005 strar's Signature 31. Date filed (Month) State Registrar

Margaret Swiggard

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2005 **Physician** Agnes Caroline Smith July 21, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Glade Valley Nursing & Rehab Center Frederick Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 23, 1917 5 Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 🖸 F 88 Maryland Director 217-01-9064 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a State 10h County 10d. Inside City Limits or 28a-f show treumatic event, the Medical Examiner must be notified at Thurmont 1 **3**Yes 2 □ No Frederick Md. Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 21788 301 W. Main St. U.S.A or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status s 1 and 2 should be filed within 72 hours after f Health and Mental Hygiene. Item 27 is marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Anna C. Wills Joseph William Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James R. Smith (Son) 305 W. Main St. Thurmont, Md. 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State perrit. Pages 1 Dep rtment of H Importent: If Ite any Injury or ot once. July 23, 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Smithsburg Crematory ^ 4 □ Donation 5 □ Other (Specify) Smithsburg, Md. 2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg, Md. 21783 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as i consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed burial-transit attending physician end resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 1 ☐ Yes 2 No the 9 Unknown 9 Unknown ģ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 1 Tes 2 No 1 Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: No No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide hours after within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License numbe 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) empleted cause of death (Item 23a) (Type, Print) 32. Registrar's Signatur State Registrar

		For Stete Registrar	Sta	ate of N	Marylan	-	artmen rtificate				lental Hy	giene Reg. 20	05	25052
Physicia /Medic		1. Decedent's Name (First, Middle LILLIAN MARI	E SIM					-			2. Date of De Month	5, 200	•	3. Time of Death 21:18P M
Examin	er	4a. Facility Name (If not institution Atlantic Genera 5. Social Security Number	_	ital		last birthday)	Ber	lin	Location of		8 Date of Bi	Word	ester	
Funeral Director		179 03 0759 Usual Residence of Decedent	1□ M 2		90	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, Da Feb.	8,1915	Per	nplace (State or Foreign untry) nnsylvania
e Marylan a-f show	ctor	10a. State 10b. County Maryland Word	ester		10c. Cit	y, Town or Lo lin	ocation							10d. Inside City Limits 1 XYes 2 □ No
th with the	Funeral Director	10e. Street and Number 1 Meadow St.	Apt. Gull C		Retir	ement	10f. Zip					10g. Cîtîzen	of What Cot	untry?
STE, Maryland 21215-0036 stand 2 should be filed within 72 hours after death with the Maryland of Haalib and Mental Hygiene. Item 27 is marked other then "neturel", or items 23s or 28s-f show other traumatic event, the Medical Exertinar must be notified at	by Funer	11. Marital Status 1 □ Never Married 2 □ Marri 3 ▼ Widowed 4 □ Divorced	ied 1	as Decede med Force Yes 2 Yes, Give ar or Date	No	1	Was Deced If Yes, spec		ispanic Ori in, Mexicar Specify:		ecify Yes or No Rican, etc.)		Race - Amer Black, White Brify: Wh	e, etc.
21215-0036 within 72 hours att gleine. ret then "neturel; or the Madical Everti.	Completed t	15. Deceden (Specify only higher Elementary/Secondary (0-12)	t's Education at grade comp			(Give	dent's Usua kind of wor DO NOT us	k done d	during mos	t of work	ing		f Business/l	
d 2121 Higher within Hygiene. other then "ent, tre Me	Be Com	11 17. Father's Name (First, Middle,				Book	Bind	er	18. Mothe	ər's Namı	e (First, Middle	Printi Maiden Sun		
Maryland 2121. d 2 should be filed within th and Mental Hygiene. It is marked other then "traumatic event, the Market then".	To B	Christian Oeste 19a. Informant's Name/Relations		int)		19b. Maili	na Address	(Street a			Guigan	er. City or To	wn. State. Z	ip Code)
e, Ma 1 and 2 s 1 and 2 s Health an em 27 ls other trau		Constance A. 20a. Method of Disposition			20h F	704	West (Ches	ter (Ct.		oro, D		939
altimore, rmit. Pages 1 at partition to Heap portent: If item y injury or othe (28.		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	pecify)	al from Sta	19	Place of Disponentery, cre ape He							ford,	
Baltimo permit. Pages Department of Importent: If i eny injury or once.		21. Signature of Fundral Service	Dieche	ye_			2. Name an				rat Hom		Willian lin, N	m St. 1D 21811
Physician /Medical Examiner physician and physician and the prujal-transit	Ical Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that indiated events resulting in death) Last	a	Lue to (or Due to (or	as a consequence as a c	uence of): uence of):	One-							Interval Between Onset and Death
Box 6 death certific	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	10 40	Live birth	me of pregna 2 Feta t at time of d	I death 3[□Ectopic pr □ Other (sp					23d.	Date of deline	very Day Year
ds, Eds.	by	Part II. Other significant condition	ons contributi	ng to deati	n but not res	ulting in the u	inderlying c	ause give	en in Part I			tobacco use d		the cause of death?
Bec I Rec The taw ate has b	Completed						_ _				24a. Was auto perfe 1 \(\text{Yes}	an 24 psy prmed? 2 No	prior to o death?	topsy findings available ompletion of eause of
Vita Vita Sician:	o Be	25. Was case referred to medica examiner?	Hospita	al: 1 lings	atient 2	ER/Outpatie	nt 3□ DC	A Othe	0.00		h (Check only		Other (Spec	ifv)
	ation: T	27. Manner of Death 1 Natural 5 Pendir 2 Accident investi	gation	a. Date of li (Month,		28b. Time o Injury	_	8c. Injun Work	v at		28d. Describe			,
	Certification	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		Place of building,	Injury - At he etc. (Specif	ome, farm, st	reet, factory	, office			28f. Location (City or To	Street and No wn, State)	mber or Ru	ral Route Number,
Di To the Hospital or within 24 hours afte To the Suneral Dir	edical		Exeminer: D		s of examina						and due to the red at the time,			stated. to the cause(s)
To the Within 2 To the complete	M	29b. Signature and title < certifie	MO					xal	ol 2			29d. Date sig	5 hc	
C. H.3		30. Name and address of person	Bares	1.6	of death (Item	n 23a) (Type, 1733	Hea	the	Muy	Dr 1	Berlin	mo	2181	(
Sta Registr		31. Date filed (Month, Day, Year)	2805	32 legi	strar's Signa	b A	and .		0	10.20	1		William S	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2 0 0 5 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Yee **Physician** Mary Smith July 2005 0820 15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 54/15b4M KICOMICO REGIONAL MEDICAL CENTER Peninsula If Under 1 Year If Under Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours/ 1 ☐ M 2 🗗 F Months Days Director 024-16-2616 4/11/1921 Canada Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-1 show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event. The Medical Examinat must be notified at once. 1XYes 2 No Directo Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 111 Greenmount Ave. 21801 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2₹ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 □ Never Married 2 □ Married white Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Entrepenuer Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Majloire Caron Florida Dumont 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Lee Smith/son 30481 Danwood Dr., Delmar, MD 21875 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cemetery 7/18/05 Baltimore, MD ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804

Approximate 21 Signature of Funeral Service Licensee Donupson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final respiratory **Physician** disease or condition resulting in death) /Medical Examiner conce Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine been signed by the attending physicien and should be detached for use as the burial-transit be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No this certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 22 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral. 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier f 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies 022180 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who SALISBURY MO 2/80) 100 E CARROLL ST I NAGEL, MD JUL 1 8 2005 32. Pagistrar's Signature 31. Date filed (Month, State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death July **Physician** 16 2005 9:30 P Rena Rita Sikora /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Somerford Place Assisted Living Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct. 9, 1929 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1□ M 2 AF 75 202-22-4924 Pennsylvania Director Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is merked other then "natural", or itema 23a or 28a-f ehow any injury or other traumatic event, the Medical Exact for menter indifficulations. 10a. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Prince George's Bowie 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 20715 USA 2606 Kingsley Lane Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 201No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes 2 No Specify. Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Day Care Provider 1217. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maria Gretolla James DeFrancesco ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2606 Kingsley Lane Bowie. MD. 20715 Nancy Sikora / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 07/22/2005 | Philadelphia, PA. * 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee 6512 NW Crain Hwy. Bowie, Maryland 20715 11 00 an 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Myocardial infarction /Medical Due to (or as a consequence of): Examiner Coronary artery disease vears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the ettending physicien and I be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 9☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Ischemic cardiomyopathy Completed been Alzheimer dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No Hypothyroidism 1□ Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Hospital: 1 ☐ Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 $hreve{X}$ Other (Specify) $ext{Living}$ 1 Yes 2 No ٥ 2 ER/Outpatient 3□ DOA 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Perfect death.

Director: After the by the funeral Certification: 1 Natural 5 Pending Injury 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospitel within 24 hours e To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 10 2005 225 18, TULY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6510 Kenilworth Ave. G.M. Din, M.D. Suite 2600 Riverdale, MD, 20737 filed (Month Day Year) 32. Registrar's Sig State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 16ay 2005 7:25 RM **Physician** Μ. Scott Agnes /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Frederick Calvert Calvert Memorial Hosptial | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | June 27, 1916 | Washington, DC 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🔀 F 89 216-50-5478 Yrs. Director Usual Residence of Decedent with the Marylend 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examiner must be putified at MD Prince George's Cottage City 1 Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20722 United States 3707 40th Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Black, White, etc. filed within 72 hours efter Hyglane. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Clerk F.B.I. permit. Peges 1 end 2 should be filed wit Dapartment of Health and Mental Hygians Important: If Item 27 Is marked other that any Injury or other traumatic event. That ODG. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Liversedge Edward Joseph McGee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 142 Brentwood, MD 20722 3705 40th st. John V. Scott (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

TBurial 2 Cremation 3 Removal from State Date 20c. Location - City or Town, State Fort Lincoln Cemetery 7/21/2005 Brentwood, MD '4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service License 3401 Bladensburg Road Brentwood, MD 20722 Luhar 23a. Part1. Enter the dist ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ges tive Physician Con nine disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed use as the burial-transit and resulting in death) Last Due to (or as a consequence of) attanding physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown been signed by to should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 25 Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 Ho 1 Hipatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? or Attending within 24 hours after death. To the Funeral Director; After Injury 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif eted cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

			1 - For State of Maryla Recistrar		artment of H			giene 005	25056
			Decedent's Name (First, Middle, Last)				2. Date of Dea	ath	3. Time of Death
	Physicia /Medic		Margaret Southall				July 13	Day Year 2005	11:20 AM
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	r Location of		4c. County of Dea	ath
			Collington Nursing Home		Mitchelly			Prince Ge	
	Funeral		ACTIVITY OF THE	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	8. Date of Birt Min. (Month, Da June 5	h y, Year) 9. Bi	rthplace (State or Foreign country)
	Director		578-62-2234 1 89	-			June 3,	1916 Vi	rginia
	/land			City, Town or Lo	ocation				10d. Inside City Limits
	Man,	į	D.C. N/A W	ashingt	on				1 X Yes 2 □ No
	h the	lrec	10e. Street and Number		10f. Zip Code			10g. Citizen of What C	country?
	23a c	aic	4407 Edson Place, N.E.		20019			United St	
	tems	Funeral Director	11. Marital Status 12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origi an, Mexican,	n? (Specify Yes or No- Puerto Rican, etc.)	- 14. Race - Am Black, Wh	
36	filed within 72 hours after death with the Maryland Hygiene, ther than "natural", or items 23a or 28a-f show ent. The Madical Examiner must be notilled at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1 ☐ Yes 2 🗓 No	Specify:		Specify: B1	ack
Ş	tural	edt	15. Decedent's Education	16a. Dece	dent's Usual Occup	ation		16b. Kind of Busines	s/Industry
715	7 nin 72	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most o d)	of working		
21:	giene giene pr the	Completed	5+	Teac	her			D.C. Publi	c Schools
п	al Hy al Oth doth	Be (17. Father's Name (First, Middle, Last)				s Name (First, Middle,	Maiden Sumame)	
yla	Ment Ment arke	ို	Harry Branson				rude Brown		
Maryland 21215-0036	2 sh and is m		19a. Informant's Name/Relationship (Type, Print)					er, City or Town, State,	
e,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In the Marylan I is marked other than "natural", or litema 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		Carolynne G. Branson/ Niece 20a. Method of Disposition				N.E., Wasni Date	ington, D.(
סב	nt of 1		1 Buriai 2 Laternation 3 Linemoval from State		osition (Name of matory or other place		7/10/05		
Baltimore,	artme artme ortant injury		* 4 □ Donation 5 □ Other (Specify) (21. Signature of Funeral Service Licensee		ke Cremat			Beltsville Ineral Serv	
Ba	Depri Impo		John on to Allsberry				e. N.W., Wa		20012
			23a. Pan). Enter the disease, or complications that caused the d shock, or heart failure. List only one cause on each/lihe.						Approximate Interval Between
3	Pnysician :		Immediate Cause (Final				DEME	100	Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as a con-		200 21	114/	DEME	WIJI	2 7121NG_
В	Examiner		Sequentially list conditions b. MALN	TRITT	ON				6 MONTHS
	D :=	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	saquanos or,:					
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a con:	sequence of):					
8760,	The law requires that the death centificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	icai E	250.10 (0) 25 25 25						
687	ficate phys s the	edic	d						
Box (leath certific attending pl	N N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pre					23d. Date of de	Blivery
Ď.	death e atte d for	Physician/M	in the past 12 months? 1 Ves 2 No. 4 Pregnant at time		□Ectopic pregnancy □ Other <i>(specify)</i>			Month	Day Year
P. O.	t the by the tache	hys	9 ☐ Unknown						
S,	res that the de signed by the a be detached f	by P	Part II. Other significant conditions contributing to death but not	_				bacco use contribute	
ord	w requir been si should	ted	ATHEROSCLERONG CA			AC	_ 101	/es 2,⊠No 3∏F	robably 4 □Unknown
ecc	iaw r as be	Completed	DISEASE, BIPOLAR I	DIS ORC	DER		24a. Was autop	prior to	utopsy findings available completion of cause of
<u> </u>	the cate h	Con	,				1 Tes	rroed? death? 2No 1 ☐ Ye	s 2 No
Vita Vita	sician: The law s certificate has b lirector, page 2 s	Be	25. Was case referred to medical examiner? Hospital:		Othe	an 23370	f Death (Check only o		
o	ding Phys	. T	T Inpatient 2		nt 3L DOA	4 Kinuis		lence 6 Other (Spa	ecify)
on	ding th. After fune	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year	r) Injury	Worl	k? Yes 2.⊟No	0		
Division of Vital Records,	or Attendi after death, Director: A i in by the fu	Certification;	3 Suicide 6 Could not be 28e. Place of Injury - A	At home, farm, st	reet, factory, office		28f. Location (S City or Tow	Street and Number or F	Tural Route Number,
á	al or A s after N Direct	Cert	4 Homicide detailmed building, etc. (Sp.	eciry)			City of You	iii, State)	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h. completely filled in by the funeral director, page	edical (29a. Certifier (Check only (Ch						
	the H nin 24 the F nplete	ledi	one) and manner stated.						
	with To con	Σ	29b. Signature and title of certifier		29c. License			29d. Date signed (Mon	· ·
	8		- Killing		1)4	160	77	1-14-	US
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) ENWAN C	מח מה	4113	7-14- REENBE 2077	ci, mo
	Sta	te.	31. Date filed (Month, Day, Year) 32 Registrar's Si	gnature	- CONTRACTO	IN UK	++113	007)	<i></i>
	Sia Registr		31. Date filed (Month, Day, Year) JUL 18 2005 32. Registrar's Si	K. As	are				

-			1 - State Registrar Co	partment of Health and Mental Hygiene ertificate of Death Reg. N2 0 0 5 2 5 0 5 7
	Physici /Medi	cal	1. Decedent's Name (First, Middle, Last) Ophelia W. Travers 4a. Facility Name (If not institution, give street and number)	2. Date of Death Month July 10, 2005 4b. City, Town, or Location of Death 4c. County of Death
	Examir Funeral	ner	Clinton Nursing & Rehab Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Clinton Prince George
	Director Mount	ı.	S79-32-3791 1 M 2 MF 83 Yrs. Usual Residence of Decedent 10a. State 10b. County Maryland Prince George Temple	
	h with the Mi 23a or 28a-f	Funeral Director	10e. Street and Number 3408 25th Place	10f. Zip Code 10g. Citizen of What Country? 20748 United States
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other then "natural", or Itema 23a or 28a-f show important: if Item 27 is marked other then "natural", or Itema 23a or 28a-f show yinjury or other traumatic event, I're Modical Exarching must be rightled at ance.	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates:	3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 No Specify: 14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	filed within 72 h Hygiene ther then "natu ent, the Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11th Pos	cedent's Usual Occupation ve kind of work done during most of working L DO NOT use retired Stage Stamp Examiner Federal Government
Maryland	should be fill nd Mental H marked oth	To Be	17. Father's Name (First, Middle, Last) Ernest Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	18. Mother's Name (First, Middle, Maiden Sumame) Queen R. Williams illing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	ages 1 and 2 nt of Health a : if Item 27 is or other trau		20a. Method of Disposition 1	20c. Location - City or Town, Slate rematory or other place) National Cem Aug. 11,2005 Arlington, VA.
Baltimore,	permit. Pa Departmen Important any injury		+ Ebonation of Control (opposity)	22. Name and Address of Facility Pope Funeral Homes 5538 Marlboro Pike Forestville, MD. 20747
8760,	Medical Examiner hysician and his burial-fransit	licai Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not eshock by heart failure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) Squentially list produces if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	Approximate such as cardiac or respiratory arrest, Approximate such a
.O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5	3 □Ectopic pregnancy 5 □ Other (specify) Month Day Year
Records, P.	aw requires that s been signed b s should be deta	Completed by PI	Part in. Other significant contained a contributing to death but not resulting in the	1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were au/lopsy findings available
of Vital	Physician: The this certificate har director, page	To Be	25. Was case referred to medical examiner?	of 28c. Injury at 28d. Describe how injury occurred
Division	al or Attending safter death. I Director: After d in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No Street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	bath occurred at the time, date and place, and due to the cause(s) and manner as staled. Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier	29d. License number 29d. Date signed (Month, Day, Year) July 14, 2005
a			30. Name and address of person who completed cause of death (Item 23a) (Typ Laxmi Berwa, M.D. 7700 Old Branch A	
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signalure	nt of the second

State of Maryland / Department of Health and Mental Hygiene For Stete Registrer Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 15, 2005 July 8:16P В. Tapscott-Gladden /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Montgomery Takoma Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1 □ M 2 T F Washington, DC **Director** 577-48-07<u>25</u> Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menlal Hygiene. Important: If Item 27 is marked other then "neturel", or Items 23e or 28e-f show eny injury or other treumatic event, It s Machael Exp. input. Items the notified as 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 Yes 2 □ No Prince Georges Hyattsville MD **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 20781 U.S.A. 5400 39th Avenue Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No 11. Marital Status 1 ☐ Never Married 2 X Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Government 12thSecretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Ward Nathaniel Belcher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Thomas Gladden/Husband 5400 39th Avenue Hyattsville, MD 20781 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 07-23-2005 Landover, MD Harmony Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JB Jenkins Funeral Home 21. Signature of Funeral Service, Licensee 7474 Landover Rd LAndover, MD 20785 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence of): **Examiner** time S- uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Il-transit The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician a hed for use as the burial-Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. ð pe 1 Yes 2 No 3 Probably 4 Donknown page 2 should Completed need 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2□ No certificate Yes 2 No 1 Yes Division of Vital To the Hospitel or Attending Physician: rector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 2 ER/Outpatient 3 DOA this funeral dir Inpatient of Death Injury at Work? 28d. Describe how injury occurred Certification: After Injury Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after dealt To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 4 Homicide 29a. Cartifier Exertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 1889 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STE340, TAROMAPARK 7610 CARRULL AVE MOBARAL 12ARIM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** July 18. 2005 4:30 <u>Patricia Ann Turgeon</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles Waldorf 910 McIver Drive 8. Date of Birth (Month, Day, Yea If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 X F 73 Director 579-36-0506 1931 Washington DC Usual Residence of Decedent the Manyland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Item 27 is marked other then "natural", or items 23s or 28e-f show other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Waldorf Directo Maryland Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? deeth with USA 20602 910 McIver Drive by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 72 hours after □Yes 2 No Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify: White Specify 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 72 th and Mental Hyglene. 7 Is marked other then "ne Elementary/Secondary (0-12) College (1-4or 5+) Medical Administrative Assistant 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Eleanor Mildred McCormick Charles Vernon Hemm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 sh Depertment of Health and Importent: If Item 27 Is rr any injury or other treum QDGs. 910 McIver Drive, Waldorf, MD 20602 Joseph H. Turgeon - Son 20a. Method of Disposition
1 △ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 7-22-05 Waldorf, MD Trinity Memorial Gdns 4 Donation 5 Other (Specify) 22. Name and Address of Facility Huntt Funeral Home P. O. Box 156, Waldorf, MD 20604-0156 M00053 Approximate Interval Between Onset and Dear Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part1 Immediate Cause (Final U) Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner anding physician and use as the burial-transit certificate be executed Due to (or as a consequence of): the attending physician P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) n signed by the a lid be detached fo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, þ 1 es 2 No 3 Probably 4 Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes 20 No 1 Yes 2 No Hospitel or Attending Physicien: 24 hours after death. Funerel Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 700 3 DOA 2 1 Inpatient 2 ER/Outpatient Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospitel of within 24 hours at To the Funerel D 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29d. Date signed (Month, Day, 29b. Signature and title of certifier c. License number who completed cause of death (Item 23a) (Type, Print) 30. Name/and address of person Н. Wathen, 11345 Pembrooke George Sq., Waldorf, MD 20602 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** лп.у 18, 2005 ELIZABETH ALSTON TYLER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ST. MARY'S COUNTY CALIFORNIA 45240 WOODSTOWN WAY If Under 1 Year | II Under 24 Hrs. 8. Date of Birth Month, Day AUGUST 12 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Year) 1928 Months Days Hours Min. 1 □ M 2007 NORIH CAROLINA 241-58-2326 76 **Director** Usual Residence of Deceden 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Director ST. MARY'S CALIFORNIA MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4520 WOODSTOWN WAY 238 20619 UNITED STATES death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ANo 'natural', or items 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Saltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates: Specify: BLACK þ 3 XWidowed 4 ☐ Divorced eted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Compl Elementary/Secondary (0-12) 8TH GRADE College (1-4or 5+) PUBLIC SCHOOL SYSTEM COOK permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien Important: Il tiem 27 is marked other this any injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be FANNIE JONES ALSTON DAVE ALSTON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CAROL TYLER WALKER / DAUGHTER 45240 WOODSTOWN WAY, CALIFORNIA, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State NOW FAITH CHURCH CEMETERY JULY 23,2005 KNIGHIDALE, NORTH CAROLINA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensea.

INDIA C. THORNION JOHNSON MOSS3 for THORNION FUNERAL HOME, P.A. INDIAN HEAD, MARYLAND for JENNIS TONEY-CARPENIES of C. J. WILLIAM TONEY'S FUNERAL HOME, INC. SPRING HOPE, NORTH CAROLINA

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line.

Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Strake /Medical Due to (or as a consequence of) Examiner mestery on Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine burial-transit death certificate be executed and Due to (or as a consequence of): Box 68760 physician Physician/Medical the SS attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No certificate has 28 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 25No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death al or Attanding Patter death.

Diractor: After Certification: 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 🗌 Homicide within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 19 2000

State Registrar

P.O.

JUL 1 9 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID J. TARDIO, M.D. 110 HOSPITAL ROAD, SUITE 310, PRINCE FREDERICK, MARYLAND 20678 32. Redistrar's Signature

177610

			For State Registrar	State of Maryland	d / Depa		f Health ar	-	_	n 5	25061	
	Physici /Medic		1. Decedent's Name (First, Middle, Last Mae E. T					2. Date of De Month	Of Fox		3. Time of Death	
	Examin Funeral Director		5. Social Security Number 6. Se	1925 Hospi	ast birthday) Yrs.	If Under 1 Ye			Prin	9. Birthp	Georges place (State or Foreign ntry)	
		10	Usual Residence of Decedent 10a. State 10b. County Maryland Prince G		, Town or Lo						10d. Inside City Limits 1Ã Yes 2 ☐ No	
	with the Mi a or 28a-f the notifie	Direct	10e. Street and Number 7212 Hylton Stre			10f. Zip Coo	20743		•	g. Citizen of What Country? United States		
36	filed within 72 hours after death with the Maryland Hygiene. uthar than "naturel", or items 23a or 28a-f show sht, fre Medical Examinar mast be mulfied at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	S. 13.	Was Decedent If Yes, specify (n? (Specify Yes or No Puerto Rican, etc.)		ace - Americ lack, White, sity: B1a	etc.	
Maryland 21215-0036	be filed within 72 hou tal Hygiene. d other then "nature event, ine Madical E	Completed	15. Decedent's Edd (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Oo kind of work do DO NOT use re Homemal	one during most o stired)	of working	16b. Kind of	Business/Ind	dustry	
yland 2	ed la be	To Be Co	17. Father's Name (First, Middle, Last) George H. Brown				A1m	s Name (First, Middle a Ramsey				
	nd 2 s lith ar 27 is r treu		-19a. Informant's Name/Relationship (T) Charles W. Thomas	, Jr./Son	7212	Hylton	St. Sea	or Rural Route Numb t Pleasant		n, State, Zip 20743		
Baltimore,	permit. Pages t al Depertment of Hea Importent: If Item any injury or othe once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify,	Hemoval from State		osition (Name of matory or other Nation		Date 1y 18,2005	20c. Location			
Baltin	permit. Pages Depertment of Importent: If if any injury or once.		21. Signature of Funeral Service Licens	see Mile	2	2. Name and A	ddress of Facility	Pope Funer 5538 Marlb Forestvill	al Home oro Pil e, MD.	es ke 2074		
	Physician /Medical Examiner	J.	23a. Part 1. Enter the disease of comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	ilications Mat caused the death one cause on each line. a. If the content of the	Lero	ter the mode of	yperte	ms/ve f	t cant	Dise	Approximate Interval Between Onset and Death	
68760,	cate be executed by siclen and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	uence of):							
O. Box	The law requires that the death certificate by the last been signed by the attending physic age 2 should be detached for use as the boage.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of do 9 Unknown	Ideath 3[□Ectopic pregn □ Other (specif				Date of delive Month	ery Day Year	
ds, P	uires that signed t	δ	Part II. Other significant conditions co	entributing to death but not resi	ulting in the u	inderlying causi	e given in Part I.		tobacco use co Yes 2 ☐ No		the cause of death? bably 4 Hunknown	
I Records,		Completed						perf	s an 24b opsy ormed? 2 No	o. Were auto prior to co death? 1 Yes	opsy findings available ompletion of cause of	
Vital	Physicien: The this certificate har director, page	To Be (25. Was case referred to medical examiner? 1 → es 2 → No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DOA	Othor	of Death (Check only sing Home 5 ☐ Res		ther (Specit	<i>fy</i>)	
sion of	ding Ph J. After th funeral	Certification: T	1 Impater 2 Evolupater 3 DOA 4 Indising from 5 Treatment									
Division	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certific	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number or Rur								al Houle Number,	
	To the Hospitei or within 24 hours after the Funerel Dir completely filled in	Medical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Examone)	ysician: To the best of my kno liner: On the basis of examina and manner stated.	wledge, dea tion and/or in	th occurred at the nvestigation, in the number of the numb	ne time, date and my opinion, death	place, and due to the occurred at the time	cause(s) and r , date and place	nanner as s a, and due to	stated. o the cause(s)	
	To the within to the compile	M	29b. Signature and title of certifier	phate.	Ds	29c. Li	cense number	927	29d. Date sign	red (Month,	Day, Year)	
1			30. Name and address of person who of	BT& 304 6	tospi	Print)	Drive,	Charry	Mas	ry las	rd	
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signa	Ana.	K)	,					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 18/05, BW, No. Certificate of Death

Reg. No. 1- State Amend Item 26
Registrar AMEND # I Specified. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 10:23p 2005 /Medical Dario Tafur July 14. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery

9. Birthplace (State or Foreign Country) Suburban Hospital Bethesda If Under 24 Hrs. Hours Min. 1 Year Days 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 12 M 2□ F Months 60 Director Dec. 13,1944 Colombia 771 05 7026 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director **Maryland** Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 5102 Parklawn Terrace #103 20852 Items 23a Colombia Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Co Lumbian

X Yes 25 No. Specify: filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married #分 re. Maryland 21215-0036 ŏ Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Addiction Counselor Drug Rehab traumatic evant. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is markad othi any injury or other traumatic evant gones. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jose Sabas Tafur Gabriela Villegas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5102 Parklawn Terrace #103 Rockville, Maryland20852 Date 20c. Location - City or Town, State injury or other t Fabiola Azcarate / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Ft Lincoln Crematory 7/20/2005 Brentwood, Maryland * 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Incorpsee 22. Name and Address of Facility Hines Rinaldi Funeral Home 11800 New Hampshire Ave Silver Spring, MD 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** EXSANGUINATION unknowin /Medical Due to (or as a consequence of): **Examiner** Internal Hemonhaye Esquentially liet conditions; if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as - consequence of): Physician/Medical as IF FEMALE: 951 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) o. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ AT HEXY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? -0125 autopsy performed? page 22 No 1 Tyes 2 X No Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 De Yes 2 No Declined Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Standardence 6 Other (Specify) Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred To the Hospital or Attending Division 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after deatl To the Funeral Diractor: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier t 🗲 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0044394 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

State Registrar Strauss, MO

31. Date filed (Month, Pay

32. degistrar's Signature

Schanban Obspital 8600 old Georgetown Rol., Bethesda Maryland 20814

Physici		1. Decedent's Name (First, Middle, Last)							2. Date of I	3: Time of De				
/Medic		Adama	E	Bidemi	Uma	r			July 21, 2005 7:41 P					
Examin	3	4a. Facility Name (If not	_				4b. City, Tow	n, or Locatio	n of Deat	th	4c. County of Death			
				ventist Ho			Rockv		os 04 Usa			Montgom		
Funeral		5. Social Security Number 212-73-66		Sex 7. a 1 M 2 X F	Age (In yrs. las	Yrs.		ays Hours	er 24 Hrs Min	(Month,	Day, Year)	9. B	irthplace (State or Fo	
Director		Usual Residence of Dec					2			5/9/2	2005	Ma	ryland	
ehow to all			. County		10c. City, 7							10d. Inside City Limi		
288-1 e	cto	Md. Mo	ontgo	mery	Gai	tner	sburg			1 ☐ Yes 2 🙀				
ms 23a or 28a-f eho	Director	10e. Street and Number					10f. Zip Coo				-	tizen of What ${\sf G}$	Country?	
s 23a		18 West D	eer P	· · · · · · · · · · · · · · · · · · ·			2087		2-1-2-0-10	S			' ladisa	
or Ite	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4		12. Was Deceder Armed Force 1 Yes 2 If Yes, Give Year or Date:	s? ∑ No		Was Decedent If Yes, specify (1 ☐ Yes 2 ☒			to Rican, etc.)	VO-	Black, Wh	nerican Indian, nite, etc. black	
"natural", clical Exp	Completed	15.	Decedent's 8	Education	1	16a. Dece	dent's Usual Oc	ccupation	ant of we	rduna	16b. K	ind of Busines	s/Industry	
. a .	ple	Elementary/Secondary	, , , , ,	rade completed) College (1-4c	or 5+)	life.	DO NOT use re	atired)	OST OF WC	iking				
tal Hygiene. d other then event. Irs M	Con	0				noi	ne					one		
d off	Be	17. Father's Name (First) Idowu N	, Middle, Las Junir	•				_	mau	me (First, Midd Um	lle, Maiden Lar	Sumame)		
I Health and Mental Hygiene. Item 27 Ie marked other then other traumatic event. Ite M.	၉					105 11 11	- Add /0-					Tour Ct	. Zip Code) 208	
7 le n traun	l	19a. Informant's Name/I			1	196. Maiii 18 747	ng Address (Sii	er Pa	rk	urai Houle Nun Rd - #30	3 Ga	ither:	sburg, M	
Department of Health Important: If Item 27 eny Injury or other tr pnce.				acher	20b. Plac	ce of Dispo	sition (Name o	of		Date	_			
°= 5		1 ⊠Burial 2 □ Cri	1 ABurial 2 Cremation 3 Removal from State Mary land National 7/23/05 Laurel. Md.											
Departmen Important: eny Injury once.			4 Donation 5 Other (Specify) 1. Signature of Fineral Service Vicensee 1. Signature of Fineral Service Vicensee 22. Name and Address of Facility Universal Mortuary											
Dep Impo		111	11 11	1 13.14	064								n,DC 200	
P		23a. Part 1. Enter the di	sease, or cor	mplications that caus	sed the death.							ingco	Approximate Interval Betwee	
nysician Medical	3	disease or condition			Ilnovn1	ained	Doath	in In	fanci	7			Onset and Dea	
kaminer	Jer	Sequentially list condition in any, leading to immediately list conditions and the sequence of	ons,	Due to (or	Unexp1: as a consequent as a consequent	nce of):	Death	in In	fancy	y			Onset and bea	
hysicien and he burial-transit	Ilca! Examiner	Sequentially list condition if any, leading to immediates. Enter Underlying Cause (Disease or injuritat inflated events resulting in death) Last	ons, fiate g y	b. Due to (or c.	as a consequer	nce of):	Death	in In	fancy	J			Onset and Dea	
hysicien and he burial-transit	cal	Sequentially list condition if any, leading to immediates. Enter Underlying Cause (Disease or injurithat initiated events	ons, diate g	b. Due to (or control of the control	as a consequer	nce of): nce of):	Death	in In	fancy	y				
he attending physicien and led for use as the burial-transit	cal	Sequentially list condition if any, leading to immediate. Enter Underlying Cause (Disease or injurithat initiated events resulting in death) Last	gnant ths?	Due to (or decomposed to the control of the control	as a consequer as a consequer as a consequer me of pregnanc 2 Fetal de t at time of deal	nce of): nce of): cy eath 3[Death Death	ancy	fancy	y	-	23d. Date of d Month		
gned by the attending physicien and be detached for use as the burial-transit	by Physician/Medical	Sequentially list condition and the sequentially list condition and the sequential sequential and the sequential sequenti	gnant ths?	Due to (or decided by the control of	as a consequent at time of death	nce of): nce of): nce of): cy eath 3[th 5[]Ectopic pregn] Other (specif)	ancy		23e. Di	-	Month use contribute	lelivery	
ite has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	Sequentially list condition of any, leading to immediate. Enter Underlying Cause, Disease or injurith at initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregint the past 12 mon 1 Yes 2 No 9 Unknown Part II. Other significan	gnant ths?	Due to (or decided by the control of	as a consequent at time of death	nce of): nce of): nce of): cy eath 3[th 5[]Ectopic pregn] Other (specif)	ancy		23e. Di 1[24a. Wa	Yes 2 as an topsy fromed?	Month use contribute No 3 F 24b. Were a prior to death?	lelivery Day Year to the cause of deatl Probably 4 Aunkr	
ite has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical	Sequentially list condition of any, leading to immediate. Enter Underlying Cause, Disease or injurithat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent preinthe past 12 mon 1 Yes 2 Mo 9 Unknown Part II. Other significants	gnant ths?	Due to (or d. Due to (or d. 23c. If yes, outcor 1 Live birth 4 Pregnant 9 Unknown contributing to death	as a consequer as a consequer as a consequer me of pregnanc	nce of): nce of): reach 3[th 5[ing in the u	⊒Ectopic pregn □ Other (specif) Inderlying cause	ancy y) e given in Pa	nt I.	23e. Di 1[24a. Wi au pe 11 Yes	d tobacco u Yes 2 as an topsy formed? 2 \(\text{No} \) No y one)	Month use contribute No 3 F 24b. Were a prior to death?	to the cause of death Probably 4 Junking autopsy findings ava o completion of cause ps 2 No	
ite has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Sequentially list condition any, leading to immediate. Enter Underlying Cause, Disease or injurthat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent preinthe past 12 mon 1 Yes 2 Mo 9 Unknown Part II. Other significant examiner? 1 Yes 2 No	gnant ths?	Due to (or decided by the contributing to death	as a consequer as a c	nce of): nce of): reath 3[th 5[ing in the u	□Ectopic pregn □ Other (specif) Indertying cause	ancy ancy	nt I.	23e. Di 1[24a. Wu ape 11/2 Yes ath (Check on)	d tobacco u Yes 2 as an topsy formed? 2 No	Month use contribute No 3 F 24b. Were a prior to death? 1 Ye 6 Other (Sp	belivery Day Year to the cause of deatl Probably 4 Junko autopsy findings ava o completion of cause as 2 \(\text{No} \)	
ite has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Sequentially list condition of any, leading to immedicause. Enter Underlying Cause (Disease or injurthat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregin the past 12 mon 1	gnant ths?	Due to (or decided by the contributing to death to the contribution of the contributio	as a consequer b 2 Fetal de at time of deat b but not resulti attient 24XEF njury ay Year) 24	nce of): nce of): nce of): cy eath 3[th 5[r/Outpatie 8b. Time c	□Ectopic pregn □ Other (specif) Inderlying cause nt 3□ DOA f 28c.	ancy y) a given in Pa 26. Pla Other: 4 Injury at Work?	rt I. Ice of De Nursing I	23e. Di 1[24a. Wi au pe 11 Yes	d tobacco u Yes 2 as an topsy formed? 2 No	Month use contribute No 3 F 24b. Were a prior to death? 1 Ye 6 Other (Sp	to the cause of death Probably 4 Junking autopsy findings ava o completion of cause ps 2 No	
 After this certificate has been signed by the attending physicien and funeral director, page 2 should be detached for use as the burial-transit 	To Be Completed by Physician/Medical	Sequentially list condition of any, leading to immediate. Enter Underlying Cause. Enter Underlying that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregin the past 12 mon 1 yes 2 No 9 Unknown Part II. Other significant 25. Was case referred to examiner? 1 yes 2 No 27. Manner of Death 1 Natural 5 2 Accident 2 Accident 6	gnant ths? t conditions medical Pending investigati Could not	Due to (or d. 23c. If yes, outcorn	as a consequer b 2 Fetal de tat time of death h but not resulting attient 2 XXEF njury ay Year) 2 1	nce of): nce of): nce of): eath 3[th 5[and the companies of the comp	DEctopic pregn Other (specify Inderlying cause ont 3 DOA of 28c.	ancy 26. Pla Other: 4 Injury at Work? 1 Yes 2	rt I. Ice of De Nursing I	23e. Di 1[24a. Wi au pe 11/2 Yes ath (Check on) Home 5 Re 28d. Describ	d tobacco u Yes 2 as an topsy rformed? 2 No y one) sidence e how injure	Month use contribute No 3 F 24b. Were a prior to death? 1 FYe 6 Other (Sp	to the cause of death Probably 4 Junko autopsy findings ava c completion of cause as 2 No pecify) unk	
 After this certificate has been signed by the attending physicien and funeral director, page 2 should be detached for use as the burial-transit 	To Be Completed by Physician/Medical	Sequentially list condition of any, leading to immediate. Enter Underlying Cause. Enter Underlying that infliated events resulting in death) Last IF FEMALE: 23b. Was decedent pregin the past 12 mon 1 Yes 2 No 9 Unknown Part II. Other significan 25. Was case referred to examiner? 1 Yes 2 No	gnant ths? t conditions o medical	Due to (or decided by the contributing to death Due to (or decided by the contributing to death Due to (or decided by the contributing to death Due to (or decided by the contribution to death) Due to (or decided by the contribution to death)	as a consequer at 2 Fetal de t at time of deat h but not resulti at ient 2 XEF njury ay Year) 1 Injury - At hom atc. (Specify)	nce of): nce of): nce of): readth 3[th 5[readth 5	DEctopic pregn Other (specify Inderlying cause ont 3 DOA of 28c. pM reet, factory, off	ancy 26. Pla Other: 4 Injury at Work? 1 Yes 2	rt I. Ice of De Nursing I	23e. Di 24a. Wu appe 11/2 Yes ath (Check on) Home 5 Re 28d. Describ	d tobacco u Yes 2 as an topsy rformed? 2 No y one) sidence e how injure (Street arrown, State	Month use contribute No 3 F 24b. Were a prior to death? 1 Ye 6 Other (Sp ry occurred	to the cause of death Probably 4 Junko autopsy findings ava o completion of cause as 2 No necify) unk Rural Route Number, st Deer Pa	
 After this certificate has been signed by the attending physicien and funeral director, page 2 should be detached for use as the burial-transit 	Certification: To Be Completed by Physician/Medical	Sequentially list condition of any, leading to immediate. Enter Underlying Cause. Enter Underlying Cause (Disease or injurithat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent present the past 12 mon 1 Yes 2 M No 9 Unknown Part II. Other significan 25. Was case referred to examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Yes No 27. Manner of Death 1 Natural 6 A Homicide	gnant ths? t conditions o medical Pending investigate Could not determine	Due to (or decided by the contributing to death Due to (or decided by the contributing to death Due to (or decided by the contributing to death Due to (or decided by the contribution to death) Due to (or decided by the contribution to death)	as a consequer at a time of deat at time of	R/Outpatie 8b. Time c 1 to farm, st 1 cent second	□Ectopic pregn □ Other (specif) Inderlying cause Int 3□ DOA If 28c. Int 28c. Int 3□ bed	ancy 26. Pla 26. Pla Other: 4 Injury at Work? 1 Yes 2	nt I.	23e. Di 1[24a. Wa au pe 1th Yes ath (Check on) Home 5 Re 28d. Describ 28f. Location City or 1 #303, G	d tobacco u Yes 2 as an topsy rformed? 2 No y one) asidence e how injured. (Street arrown, State	Month use contribute No 3 F	to the cause of death Probably 4 Junko autopsy findings ava p completion of cause as 2 No pecify) unk Rural Route Number St Deer Pa	
 After this certificate has been signed by the attending physicien and funeral director, page 2 should be detached for use as the burial-transit 	Certification: To Be Completed by Physician/Medical	Sequentially list condition and the cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnent the past 12 mon 1 Yes 2 M No 9 Unknown Part II. Other significan 25. Was case referred to examiner? 1 Yes 2 No No 27. Manner of Death 1 Natural 5 Accident 3 Surcide 6 Homicide	gnant ths? t conditions o medical Pending investigati Could not determine	Due to (or decided by the contributing to death to the contributing to death to the contributing to death the contribution the	as a consequer at 2 Fetal de at at time of deal at time of	eath 3[PVOutpatien Bb. Time c 155" 10 y 10 y	DEctopic pregn Other (specify Inderlying cause Int 3 DOA If 28c. pM reet, factory, off S bed h occurred at the	ancy 26. Pla Other: Injury at Work? 1 Yes 2	nt I.	23e. Di 24a. Wi au pe 10 Yes ath (Check on) Home 5 Re 28d. Describ 28f. Location City or 1 #303, G. e, and due to the	d tobacco u Yes 2 as an topsy rformed? 2 No y one) sidence e how injure (Street arrown, State aithe	Month use contribute No 3 F 24b. Were a prior to death? 1 FYe 6 Other (Spry occurred Number of H 18 West Sburg. and manner a	to the cause of death Probably 4 Junking autopsy findings ava to completion of causing as 2 No Rural Route Number, The Part Aryland as stated.	
 After this certificate has been signed by the attending physicien and funeral director, page 2 should be detached for use as the burial-transit 	To Be Completed by Physician/Medical	Sequentially list condition of any, leading to immedicause. Enter Underlyim Cause. Disease or injurthat infliated events resulting in death) Last IF FEMALE: 23b. Was decedent pregin the past 12 mon 1 Yes 2 No 9 Unknown Part II. Other significan 25. Was case referred to examiner? 1 Yes 2 No No 27. Manner of Death 1 Natural 5 Natural 5 Accident 3 Suicide 6 AU Homicide	gnant ths? t conditions o medical Pending investigate Could not determine Certifying F	Due to (or decided by the contributing to death Due to (or decided by the contributing to death Due to (or decided by the contributing to death Due to (or decided by the contribution of the contribution	as a consequer at 2 Fetal de at at time of deal at time of	eath 3[PVOutpatien Bb. Time c 155" 10 y 10 y	Dectopic pregn Other (specify Inderlying cause Int 3 DOA Int 28c. p M reet, factory, off S bed h occurred at the twestigation, in recognition.	ancy 26. Pla 26. Pla Other: 4 Injury at Work? 1 Yes 2 fice the time, date my opinion, contents on umber	nt I. Ice of De Nursing I	23e. Di 24a. Wi au pe 10 Yes ath (Check on) Home 5 Re 28d. Describ 28f. Location City or 1 #303, G. e, and due to the	d tobacco u Yes 2 as an topsy rformed? : 2 No y one) asidence e how injuit (Street arr own, State aithe e cause(s) e, date and	Month use contribute No 3 F 24b. Were a prior to death? 1 Ye 6 Other (Sp ry occurred 18 West rsburg, and namner and place, and did	to the cause of death Probably 4 Junking autopsy findings ava to completion of causing as 2 No Rural Route Number, The Part Aryland as stated.	
eath. for: After this certificate has been signed by the attending physicien and the funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	Sequentially list condition of any, leading to immedicause. Enter Underlying Cause. Disease or injurthat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregin the past 12 mon 1 Yes 2 No 9 Unknown Part II. Other significan 25. Was case referred to examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 2 Accident 3 Suicide 6 4 Homicide	gnant ths? t conditions o medical Pending investigate Could not determine Certifying F	Due to (or decided by the contributing to death Due to (or decided by the contributing to death Due to (or decided by the contributing to death Due to (or decided by the contribution of the contribution	as a consequer at 2 Fetal de at at time of deal at time of	eath 3[PVOutpatien Bb. Time c 155" 10 y 10 y	Dectopic pregn Other (specify Inderlying cause Int 3 DOA Int 28c. p M reet, factory, off S bed h occurred at the twestigation, in recognition.	ancy 26. Pla 26. Pla Other: 4 Injury at Work? 1 Yes 2	nt I. Ice of De Nursing I	23e. Di 24a. Wi au pe 10 Yes ath (Check on) Home 5 Re 28d. Describ 28f. Location City or 1 #303, G. e, and due to the	d tobacco u Yes 2 as an topsy rformed? 2 No y one) sidence e how injuit (Street ar rown, State aithe ne cause(s) e, date and	Month use contribute No 3 F 24b. Were a prior to death? 1 Ye 6 Other (Sp ry occurred 18 West rsburg, and namner and place, and did	to the cause of death Probably 4 Junkr autopsy findings ava o completion of cause es 2 No necity) unk Rural Route Number, st Deer Pa Maryland as stated, ue to the cause(s) nth, Day, Year)	

		ر.	For	Type or Print in Black State of Maryland / D		ealth and Me	ntal Hygier	າ ^e 2005	25064			
			1 - State Registrar 1. Decedent's Name (First, Middle, Las		Certificate of L		Reg. I	NG- 0 0 0	3. Time of Death			
	Physici	an					Month [Day Year				
	/Media	al	William Henry Wear 4a. Facility Name (If not institution, give		4b. City, Town, or		uly 23,	2005 4c. County of Death	12013			
4	Examir	er	4708 Old National		Middleto			rederick				
	Funeral		5. Social Security Number 6. Se	ex 7. Age (In yrs. last birth	hday) If Under 1 Year	If Under 24 Hrs. 8	Date of Birth	9 Righ	place (State or Foreign			
	Director		220-16-3147	XM 2□F 85	rs. Months Days	Hours Min.	(Month, Day, Yei Dec. 9,	1919 Mar	yland			
	Du .		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town	or Location				10d. Inside City Limits			
	anyla shov	7			iddletown				1 Yes 2 No			
	he M	ecto	10e. Street and Number		10f. Zip Code		100	Citizen of What Cou				
	a or	급	4708 Old National	Pike P.O.Box 373		21769	log.	U.S				
	72 hours after death with the Maryland natural', or Itema 23a or 28a-f show lital Examinat must be notified at	Completed by Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of His If Yes, specify Cubar		fy Yes or No-	14. Race - Ameri	ican Indian,			
(0	riter	F	1 ☐ Never Married 2☐XMarried	Armed Forces? 1 ☐ Yes 2 2 No			can, etc.)	Black, White	, etc. White			
036	al', o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 □ Yes 2 🛣 No	Specify:		Specify:	wnite			
21215-0036	72 ho	eted	15. Decedent's Ed (Specify only highest gra	ucation 16a.	Decedent's Usual Occupa (Give kind of work done d	uring most of working	16b	Kind of Business/Ir	ndustry			
2	ithin	ig I	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)			3 d	t _			
2	lled w tygier her tl	ပ္ပ	11 17. Father's Name (First, Middle, Last)		Managei	18. Mother's Name (i	First Middle Main	Aircraf	L			
anc	ntal hed of	Be		r		· ·						
2	hould Me mark matic	10	19a. Informant's Name/Relationship (7	Ernest A. Weaver Byrdie M. Grumbi a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S								
Maryland	d 2 s th an trau		Pauline H. Weaver	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	8 Old Nation			101 777	etown,Md.			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Itema 23a or 28a-f show any injury or other traumatic event, the Mudical Experience must be notified at an ance.		20a. Method of Disposition	20b. Place of	Disposition (Name of	Dat		Location - City or T				
πO	Pages ent of ht: If i		1 ☐ Burial 2 【Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify	Removal from State	y, crematory or other place burg Cremato	I DULLY	25,	Smithsbur	q,Md.			
Baltimore,	ortan ortan Injui		21. Signature of Funeral Service Licen		22. Name and Addres			Bradbury				
m	Depar Impor any Ir		John for	Davis MO1414	J.L Davis B	Funeral Ho	m 0	sburg,Md.				
	2		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the death. Do no	ot enter the mode of dying	g, such as cardiac or r			Approximate Interval Between			
	Physician		Immediate Cause (Final disease or condition	Pancreatic Cano	er			6	Onset and Death months			
	/Medical		resulting in death)	Due to (or as a consequence of					montano			
н	Examiner		Sequentially list conditions,	b								
,-	D ii	iner	cause. Enter Underlying Cause (Disease or injury	Due to [or as a consequence of]:								
,	be executed sician and burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as a consequence o	ıf)·							
68760,	be e) ician buria	aiE			.,,			1				
387	icate phys s the			d								
Box (death certificate e ettending physi d for use as the I	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of deliv	ery				
ğ	d for	ciai	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year			
0	that the di ed by the detached	hys	9 🗆 Unknown	9□ Unknown 								
o,	The law requires that the tee has been signed by the bage 2 should be detache	o yc	Part II. Other significant conditions of	ontributing to death but not resulting in	the underlying cause give	n in Part I.		o use contribute to I				
ord	w require been si should t						1 🗆 Yes	2. No 3 □ Pro	bably 4 Unknown			
Records,	e law ru has be je 2 sh	Completed					24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of			
R		Con					performed′ 1 ☐ Yes 2 🔀 I		2 🗆 No			
Vital	ician: Th certificate ector, pag	Be (25. Was case referred to medical examiner?			26. Place of Death (Check only one)					
of \	shys this	ို	1 Yes 2 XNo	Hospital: 1 Inpatient 2 ER/Out		4 Indising Home	****	6 ☐Other (Speci	fy)			
n C		lon	27. Manner of Death 1 Natural 5 Pending		ijury Work	at ? ′es 2 □ No	d. Describe how in	ljury occurred				
Division	Attending r death. sctor: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be				f. Location (Street	and Number or Run	al Route Number.			
⊃i	after Direct in by	ertif	4 ☐ Homicide determined	building, etc. (Specify)	in, stroot, ractory, cinco		City or Town, St.					
	To the Hoapital or Attens within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 X Certifying Ph	ysician: To the best of my knowledge,	death occurred at the tim	e, date and place, and	d due to the cause	(s) and manner as s	stated.			
	e Hos 24 h e Fur etely	Medicai		iner: On the basis of examination and and manner stated.								
	To th	Me	29b. Signature and title of certifier		29c. License	number	29d. [Date signed (Month,	Day, Year)			
)			· Cuestin	Vearr V.	D09689		Ju1	y 25, 200	5			
	,		30. Name and address of person who	completed cause of death (Item 23a) (1	, ,				
	6		A. Austin Pearre,	Jr., MD, 300 West	Ninth Stre	et, Freder	ick, MD	21701				
	Sta	1 4	31. Date filed (Month, Day, Year)	32. Fagistrar's Signature	Since to							
	Registr	ar	AUG 0 1 2	UUD Believe St.	A STATE OF THE PARTY OF THE PAR							

Baltimore, Maryland 21215-0036

with the Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Carol Wooters Waite 2026 16,2005 July /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Eninsula Regional Medical Center alisbun Wicomica If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Nov. 18, 1941 Birthplace (State or Foreign Country)
 DE Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F 63 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at XXYes 2 No Director MD Snow Hill Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6310 Purnell St., Apt. 7 21863 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes Ž No Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teachers Aide School 3 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Wooters Grace Knowles Matthai 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an ant: if itam 27 ie i Bonnie W. Willey 5806 Evergreen Terrace, Snow Hill, Md. 21863 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Qther (Specify) Bates Cemetery 7-20-05 Snow Hill, Md. 21. Signature of Fune A Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 208 W. Federal St., Snow Hill, Md. 21863 12 mbal 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): **Physician** 453 Shock disease or condition resulting in death) /Medical Examiner myocard Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Corman a Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 2 No 1 ☐ Yes Hospital or Attending Physician: 4 hours after death. Funeral Diractor: After this certifice 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation 1 🗌 Yes 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 07/17/05 D41721 mo

C. H

requires that the death certificate be executed

Division of Vital Records. P.O. Box 68760

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

MD

21804

SALUBURY

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month Decedent's Name (First, Middle, Last) Day Year **Physician** Robert Webster 2005 /Medical 4a. Eacility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MAMICO SA 13641 TONINSULO POSICA If Under 1 Year | If Under 24 Hg B. Date of Birth (Month, Pay, Yea 1/19/1921 9. Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days Months Hours 1 XM 2 □ F 84 Maryland 219-14-4764 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
int: If item 27 is marked other than "natural", or Items 23e or 28e-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ral', or items 23e or 28e-f show Examiner must be notified at 1X Yes 2 □ No Director Maryland Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 702 Riverside Pines 21801 USA Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces:
1 X Yes 2 No
If Yes, Give
Year or Dates: AITFORCE 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: white Specify: ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Carpet & Floor Covering owner/operator 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Olin Bryan Webster Verna Elizabeth Bozman 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Importent: If item 27 Is
any injury or other treu 702 Riverside Pines, Salisbury, MD 21801 June E. Webster/wife 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State 7/19/05 Wicomico Memorial Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Park 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Eu art . Enter the disease, or complished, or heart failure. List only or Approximate Interval Between Onset and Death plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. diate Cause (Final Impediate Cause (r disease or condition resulting in death) **Physician** META STATIC MERKEL CELL CANCER one week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical as the 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ö in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate 1 ☐ Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 210 No 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 2 1 🗌 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined after 4 | Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier ical within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 0 0057359 22 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. DIVISIEM ST , SALISBURY 1415. DR- US HA MATESAN 32. Rajistrar's Signature 31. Date filed (Month, Day, Year) State JUL 1 8 2005 them Registrar

4,	15		For	State of Maryland				lental Hyg	giene 2005	25067
			State Registraramended #4/w		-05Certii	icate of L	Jeath	2. Date of Dea	109.110.	3. Time of Death
н	Physici	an	1. Decedent's Name (First, Middle, Last, Ida Edna W	harton				Month	Day Year	2 10 a M
	/Medic Examin		4a. Facility Name (If not institution, give		41	o. City, Town, or	Location of Death	Aline	4c. County of Dea) 2 1
	Examili	lei	ManoKinP	JONOR		PriN	cessA	NNR	Some	rset
	Funeral		5. Social Security Numb 6925 6. Se	7. Age (In yrs. la	M	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day	h 9. Bi	rthplace (State or Foreign ountry)
	Director		222-0900023	^{1 M 2} X F 90	Yrs.	3.00		5/8/19	15 De:	Laware
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Locati	on		· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits
	Many f sho	to	Maryland Somerset	Pri	ncess A	Anne				tX Yes 2 □ No
	n the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	23e c	aD	11974 Edgehill Te	errace		21853			USA	
36	be filed within 72 hours after death with the Maryland nat Hygiene. ad other then "naturel", or items 23e or 28e-f show event, Ite Madical Examinar must be natified at	by Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 X No If Yes, Give	lf Ye	Decedent of Hises, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
21215-0036	hour furel	ed b	3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates:	16a. Deceden	's Usual Occupa	ition		16b. Kind of Business	s/Industry
15	n "na	Completed	(Specify only highest grad	e completed) College (1-4or 5+)	(Give kin life. DO	d of work done d NOT use retired,	luring most of work)	ing		·
212	d with giene ar the	E	8	——————————————————————————————————————	Seams	ress			Shirt Fact	tory
p	d 2 should be filed within hand Mental Hygiene. 7 is marked other then "treumetic event, the Mac	Be (17. Father's Name (First, Middle, Last)	. TT - 3				•	Maiden Sumame)	
Maryland	Men Marke Marke	ို	George Washingtor		405 14.35	(2)	Ida Jan		- 0'h T C	To Oaks
Mar	d 2 sh h and 7 is n treun		19a. Informant's Name/Relationship (T) Virginia Brooks/da						is, City or Town, State, isbury, MD	
	ni. Pages 1 and 2 should b a ment of Health and Ments o ent: if item 27 is marked i jury or other treumetic o		20a. Method of Disposition	20b. Pla	ace of Disposition	on (Name of		Date	20c. Location - City o	
Baltimore,	ages ant of it: If it y or c		1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	-	ory or other place Cemeter		3/05	Georgetow	m DE
===	permi. F Depa me Imporer any iriur		Senature of Funeral Service Licens							
ñ	Depa Impo any i	1	Haris H. Ho	moons CF	SP 50	I Snow H	uneral H Ill kd/.	, Salis	cessional A oury, MD 2	Association 1804
	Physician .		23a. Part1. Enter the disease, or complishock, or heart failure. List only o Immediate Cause (Final disease or condition	icati his that caused the death. ne cause on each line.		he mode of dying				Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Due o (or as a conseque	ence of):					
7.	Examiner		Sequentially list conditions,	b. STROK	E					YEAR S
	ed .	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence or):					
_6	cate be executed physician and the burial-transit	xan	that initiated events resulting in death) Last	c Due to (or as a conseque	ence of):					
8760,	siciar buris	dlcal E		d						
9	g phy as the	edic	_	0.						
D. Box	The law requires that the death certific thas been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal o 4 □ Pregnant at time of dea 9 □ Unknown	death 3□Ec	topic pregnancy ther (specify)			23d. Date of de Month	elivery Day Year
P.0	es that the de igned by the i be detached		Part II. Other significant conditions co	ntributing to death but not resul	ting in the unde	rlying cause give	en in Part I.	23e. Did to	obacco use contribute	to the cause of death?
ds.	uires n sign ild be	d by						101	res 2□No 3□F	Probably 4 Unknown
Records,	w requir	Completed						24a. Was		utopsy findings available
Re	The lav	шо						autop perfo	rmed? prior to death?	
Vital		a	25. Was case referred to medical				26. Place of Deat			
of V	S S	To B	examiner? 1 \(\text{Yes} 2 \(\text{No} \)		R/Outpatient	3□ DOA Othe	or: 4 Nursing Ho	ome 5 Resid	dence 6 ☐Other (Sp.	ecify)
			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe h	now injury occurred	
Division	teat tor:	Certification:	2 Accident investigation 3 Suicide 6 Could not be	One Blace of laive. At her			Yes 2 □ No	28f Location /6	Street and Number or F	Rural Route Number
Σį	l or Attendate death Director:	ertif	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, rann, street)	, ractory, ornes		City or Tox		ibiai / loute / to//ibe/,
_	To the Hospitel or Attending within 24 hours after death. To the Funerel Director; After completely filled in by the fune	edical C	(Check only 2 Medical Exem	sicien: To the best of my know iner: On the basis of examinati and manner stated.	pinion, death occur	red at the time,	date and place, and du	e to the cause(s)		
	ro th within Fo the	₩.	29b. Signature and title of certifier			29c. License	number		29d. Date signed (Mor	nth, Day, Year)
			1 6	mo		Dog	0629	16	07/15/	2005
6	2hP		30. Name and address of person wood	ompleted cause of death (Item PERCEZ 10 17 32. Registrar's Signate	23a) (Type, Pri	74 Ed	gehill T	Terr. P.	rincess A	21853 nne, MD
	Sta Registi		31. Date filed (Month, Day, Year) JUL 1 8	32. Registrar's Signate	ure #	parti	7			

ALEN	WATSON	1	1 - State Unpend Item	State of M 23a&27 per	aryland/ r me G 84	Depar Cert	tment of	of He	ealth a	ind M	ental Hy	giene 0 (05	25068	}
			Decedent's Name (First, Middle, Las								2. Date of Dea		Year	3. Time of Death)
	Physici /Medic		GALEN MARCEL WATS	SON							JULY	16, 20		1254 P	М
	Examin		4a. Facility Name (11 not institution, give MALCOM GROVE HOS	street and number) PITAL			4b. City, Toy CAMP	wn, or L SP	ocation o RINGS	f Death		PRIN	y of Death CE GI	EORGES	
000	Funeral Director	· ·	5. Social Security Number 5. Social Security Number 5. Social Security Number 2. Sex 1. Age (In yrs. last birthday) 2. Months Days Hours Min. Aug. 27						y, Year) Country)						
2	and wo		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Loca	ation							10d. Inside City Lim	its
	within 72 hours after death with the Maryland ene. than "naturel", or items 23e or 28e-f show the Moulcel Eversiting must be notified at	to	MARYLAND CHARLES	5	WALDO	RF								XXYes 2□1	NO
	th the M or 28a-f	Director	10e. Street and Number				10f. Zip Co	de		_		10g. Citizen of	What Cou	intry?	
	ath wi		6066 SIRENIA PLACI				20603 3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					UNITE			
	er de itama	Funerai	11. Marital Status 1 Never Married Married	12. Was Decedent Armed Forces? 1 ☐ Yes XX)	13. W	as Decedent Yes, specify	Cuban,	panic Orig , Mexican	, Puerto l	Rican, etc.)	Bla	ce - Amen ck, White	ican Indian, , etc.	
336	urs aft	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 [□Yes 2Ω	No	Specify:			Specia	ty: BLA	ACK	
5-0036	72 hou	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	168	Decede	int's Usual O	ccupat	ion irina most	of workii	na	16b. Kind of B	Jusiness/Ir	ndustry	
2121	i within 72 ho piene. r then "netu	npie	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO	O NOT use r	etired)				PRIVATE			
	led tygi t, 1		17. Father's Name (First, Middle, Last)	1 YR.			ELEC			r's Name	(First, Middle,	PRI Maiden Sumai			
and	d be file ental Hyg sed othe c event,	o Be	FREDERICK WATSON								BERLAKI		ŕ		
Maryland	nd 2 should be fi Ith and Mental H 27 is marked of traumatic ever	P_	19a. Informant's Name/Relationship (7	Гурв, Print)	19	b. Mailing	Address (S	treet an				ar, City or Town	, State, Zi	p Code)	
			LAKYCHIA WATSON /	WIFE	60	66 S	IRENIA	A PI	LACE		WALDOR	F, MD 20	0603		
ore	es 1 an of Heal f item 2 r other	13	20a. Method of Disposition XXBurial 2 Cremation 3	Removal from State	20b. Place of cemete	of Disposi ary, crema	tion (Name atory or othe	of r place))	D	ate	20c. Location	- City or T	own, State	
altimore,	Pages ment of H ant: if its lury or of		4 Donation 5 Other (Specify		RESSU						And the second s	CLINT			
Ball	permit. Pages Department of Important: If it any injury or o		21. Signature of Furiera Septice Libera	insell		MA 43	Name and A RSHALI 08 SU	Address L'S LTLA	FUNE FUNE AND R	RAL OAD	HOME OF	MARYL	AND,I	NC. 0746	
8760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit	dicai Examiner	23a. Part. Enter the disease, or commoditive. List only shock, or heart failure. List only shock or condition resulting in death) Sequentially list conditions, if any, leading to first editions. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Hyperta Due to (or as b. Due to for as c.	a consequence	cardi				cardiac o	r respiratory al	rest,		Approximate Interval Between Onset and Death	
P.O. Box 68	it the deeth certificaby the attending placehed for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal deat		Ectopic pregr Other (speci						ate of deliv	very Day Year	
	quires that n signed t uld be deti	þ	Part II. Dther significant conditions of	ontnbuting to death t	out not resulting	in the und	derlying caus	se giver	n in Part I.			obacco use con res 2□No	3 🗌 Pro	the cause of death?	
of Vital Records,	The law requate hes been page 2 shoul	Completed									24a. Was autor perfo		prior to α death?	opsy findings availal ompletion of cause of	ble of
ia i	sician: The certificate he rector, page	BeC	25. Was case referred to medical examiner?					7		of Death	(Check only o	пе)			
of V	hysic this co	၉	1X Yes 2 □ No	Hospital: 1 Inpati			3 DDA	Other	4 🗀 140			dence 6 Ot		ify)	
u C	ding Phys	ion	27. Manner of Death 1. Natural 5 ☐ Pending	28a. Date of Inji (Month, Da	ay Year) 25b.	Time of Injury	M 28c.	Work?	at ? es 2 []1		28d. Describe i	now injury occu	rred		
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In	jury - At home, t tc. (Specify)	farm, stree					28f. Location (City or To		ber or Rui	ral Route Number,	
۵	lospital of hours af uneral D	edicai Ce	29a. Certifier 1 Certifying Ph	ysician: To the best	of my knowledg	ge, death	occurred at l	the time	e, date an	d place, a	and due to the	cause(s) and m	anner as	stated.	
	the H hin 24 the F mplete	Medi		and manner s	tated.				number			29d. Date sign			
	0 3 ₹ 5		29b. Signature and title of certifier	U X	1 1/2	ens			M.E			JULY			
	HIN		30. Name and address of person who	completed cause of	death (19m 23a)) (Type, P ENN	rint) STREE	Γ, Ε	BALTI	MORE	,MARYLA	ND 2120)1		
4	Sta Registi		31. Date filed (Month, Day, Year) JUL 2 1 2003	32. Regist	rar's Signature	food	v								

	,	1	For State	State of Ma		epartment C <i>ertificate</i>					2005	25069	
			Registrar Decedent's Name (First, Middle, Las	t)					2. Date of Dea		Year	3. Time of Death	
	ysicia Medic	_	Freda Wright-So	rce					July	18	, 2005	19:42 M	
	amin		4a. Facility Name (If not institution, give University Hospit	street and number)	'rauma	4b. City,	rown, or Loca Baltin	ntion of Death		4c. (County of Death		
	neral ector		5. Social Security Number 6. Sec. 18-66-3365	9x 7. Age	(In yrs. last birth	Months		urs Min.	B. Date of Bin (Month, Da June 7	h y, Year) 195	9. Birthi Cou Mary	place (State or Foreign http) Land	
			Usual Residence of Decedent 10a. State 10b, County		10c. City, Town	or Location						10d. Inside City Limits	
Aarylar Febow	٥	_		1	t Falls						1 ☐ Yes 2X No		
the M	dia	Directo	Virginia Fairfa: 10e. Street and Number	10f. Zip C			Code	ode			en of What Cou	ntry?	
3a or 3			10612 Allenwood	Lane			22066				USA		
C Z1Z13-UU3D filed within 72 hours after death with the Maryland Hygiene. Uther than "naturel", or iteme 23e or 28e-f ehow ent, the Medical Examinar must be rediffied at	aninar mu	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 No. If Yes, Give Year or Dates:	!? If Yes, specify Cuban, Mexican, Puer]No 1 ☐ Yes 2 No Specify:				ecify Yes or No Rican, etc.)			ace - American Indian, lack, White, etc.	
VIZI 5-0036 d within 72 hours all giene.	al Ex		15. Decedent's Ed	lucation	16a. [Decedent's Usua	I Occupation				d of Business/Ir		
C 14 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Medic	Completed	(Specify only highest gra	de completed) College (1-4or 5-	·) (Give kind of wor	is retired)	g most or work	ing		0.15 7 1 1		
IG Z1Z filed withir t Hygiene.	£1	Com		4		CEO	10	Mothor's Name	First Middle		Self-Employed		
C 9 76 -		Be	17. Father's Name (First, Middle, Last) Lester L. Wrigh								Douglas	3	
ore, Maryland ss 1 and 2 should be f of Health and Mental H	matic	ဥ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State										
and 2 s	trau		Michael L. Sorce/								VA 2206		
S ar	othe		20a. Method of Disposition		20b. Place of I	Disposition (Nan	ne of ther place)		Date	20c. Loc	cation - City or T	own, State	
Page Page	ŝЬ		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Fort Li	ncoln C	remato	ry 7/12	2/2005	Brent	twood, N	D Hemo Inc	
Baltimore, permit. Pages 1 a Department of Hea	any inju		21. Signature of Funeral Service Licer Ruplin To Ille	olas I		11800 N	lew Han	npshire	Ave. S	i lve	runeral r Spring	Home, Inc.	
卷	J.		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused one cause on each lin	the death. Do no	ot enter the mod	e of dying, su	ich as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
Physi			Immediate Cause (Final disease or condition	. Multi	4 -	siurie							
î /Ме Ехап	dical	,	resulting in death)	Due to (or as a	consequence d								
3 . 1		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	a consequence o	f):							
petn	ansit	Examine	cause. Enter Underlying Cause (Disease or Injury that intitated events c.										
8760, cate be executed	the burial-transit	Еха	resulting in death) Last	Due to (or as a	a consequence o	f):							
8760 sate be e	he bu	dicai	d										
entifica	989	0	IF FEMALE: 23c. If yes, outcome of pregnancy								23d. Date of deli-	verv	
. Box 6 death certifications	for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth	3C. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)						Month Day Year		
o g	detached	nysk	1 Yes 2 No 9 Unknown	9□ Unknown									
s that	d be deta	by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									the cause of death?	
ords	should b								10	Yes 2	No 3□Pro	obably 4 Unknown	
Division of Vital Records, P tor Attending Physician: The law requires that after death.	201	Completed							24a. Was		24b. Were au prior to d death?	lopsy findings available ompletion of cause of	
The	pag	Sol							1 X Yes	2 □ No	1 Yes	2 No	
Vita	rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	• • •	patient 3 D	Other		th (Check only		S □Other (Spec	264)	
P y	ral dir	T. To	1 X Yes 2 No 27. Manner of Death	28a. Date of Injur	nt 2 XER/Out ry 28b. T	ime of	28c. Injury at Work?	4 INUISING H	28d. Describe			vehicle	
Vision of Vital	funer	ertification:	1 □ Natural 5 □ Pending 2 ✓ Accident investigation	(Month, Da)	()5	5.5(m		2 No	ar, ver	2 80	on with	ervehicle	
VIS Atte	in by the	HC	3 Suicide 6 Could not to determined		ury · At home, far	m, street, factor	y, office		28f. Location City or To	(Street an wn State	d Number or Ru	Neck Roza	
Div Ital or A	ed in	Cer			SK	eet			Busha	JHE	MID		
Hosp 4 hou	rune tely fii	edical	29a Certifier 1 Certifying P (Check only one) 27 Medical Exa	hysicien: To the best of miner: On the basis of and manner sta	examination and	, death occurred Vor investigation	l at the time, on, in my opinion	date and place, on, death occur	, and due to the rred at the time	cause(s) , date and	and manner as place, and due	to the cause(s)	
To the Hospital or within 24 hours after	ro me runeral birector, Aiter instabiling completely filled in by the funeral director.	Med	29b. Signature and title of certifies	and manner sta			c. License nu				e signed (Monti		
F 31	- 8/		Hot ()	· · · ·	1200	has	OCME			Ju1	y 11, 20	005	
-7	ブラ		30. Name and address of person who completed cause of death (Ilem 23a) (Type, Print) Out of the control of the										
			Patricia Aros	I.CA- Poll	/ -			t, Balt	imore,	Mary.	Land 212	201	
	Stanist		31. Date filed (Month, Day, Year) JUL 18 2	324 Registr	ar's Signature	Garle							
BATTER A	legist	rai	302 10 4	NO TOTAL	0 , 0								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last, Day Month **Physician** July 7:46p Sheila 12 ,2005 Α. West /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Malcolm Grow Hospital Prince Georges Camp Springs If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Ye. 7 / 19 / 54 9. Birthplace (State or Foreign Country)
N.C. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Year) 1 □ M 2 🗓 F Yrs. 579-72-9635 50 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show or than "natural", or items 23a or 28a-f sho 1 X Yes 2 No Director MD P.G. Forestville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3719 Donnell Dr.#103 U.S.A. 20745 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ X Yeo Specify: Be Completed by 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Clerk Typist Government other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be fi and Mental F Is marked of es 1 and 2 should be of Health and Menta filem 27 Is marked r other treumatic ex Thelma West ٩ Leonard Ray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 528 50th Pl. N.E. #21 Washington, D.C. 20019 Shavon West/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 5 1 ☐ Burial 2 ACremation 3 ☐ Removal from State = 5 permit. Page Department of Important: If any injury or once. Riverdale Crem 7/27/05 Riverdale, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hodges and Edwards 21. Signature of Funeral Service Licenses 3910 Silver Hill Rd.Suitland,MD 23a. Parf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Systimic Immediate Cause (Final diseas or condition resulting in death) cleroderme Physician arealer than /Medical Due to (or as a consequence of): Examiner Due to (or see consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine anding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ♠No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I ned by the a e detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, sign be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1 Yes 2 No certificate or Attending Physicien: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 🖾 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2√ No After the 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1 K Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a
To the Funerel I
completely filled To the Hospitel 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 05 1)0001223 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Debra A. Wereen, 1458 Addison Rd. South, Capitol Heights, Md. 20743 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 1 2005 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State		faryland / Dep				0 0 0	0=0=1
r ₃ €	of a Perm		state Registration # 57.8.I 1. Decedent's Name (First, Middle, La	est)			Jeani 2	Reg. N Date of Death	-000	3. Time of Death
	Physici /Medic		SARA	WA:	5HIN67	ON		JULY C	9,2005	7:05 AM
	Examin		4a. Facility Name (If not institution, gir				Location of Death		c. County of Death	
			Hebrew Home of G		Shington DC	Rockvil If Under 1 Year			iontgomer	
	Funeral Director			1□ M 253F	66 Yrs.	Months Days	Hours Min.	Date of Birth (Month, Day, Yea ay 29, 15	7)1939 Wash	place (State or Foreign intry) ington DC
	pu .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	anting.				10d. Inside City Limits
	laryla shov	ō		George's	Mitchell					1 X Yes 2 □ No
	the h	rect	10e. Street and Number	George S	MILCHEIL	10f. Zip Code		10g. C	Citizen of What Cou	untry?
	h with	ai D	10117 Wood Laur	el Way		20721		Uni	ted Stat	es
	ems ems	ner	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S. 13.	Was Decedent of H	ispanic Origin? (Speci an, Mexican, Puerto Ric	y Yes or No- can, etc.)	14. Race - Amer Black, White	
36	s afte	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☼ ② Pivorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	No	1 ☐ Yes 2 ☒ No	Specify:		Specify: Bla	ck
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show La Medical Exactinat must be notified at	ed b	15. Decedent's 8	ducation	100 Deed	dent's Usual Occup	ation	16b.	Kind of Business/li	ndustry
215	thin 7: e. an "n	Completed	(Specify only highest gi	College (1-4c	[5+]		ation during most of working d)			
	led wi lygien her th		12	41	Medica	al Accoun	ts Represen		Medica	1
and	otal H	То Ве	17. Father's Name (First, Middle, Las Guy Witcher	i)			Rita Mary 1			
Maryland	should nd Me mark imark	ř	19a. Informant's Name/Relationship	(Type, Print)	19b. Mail		and Number or Rural F			ip Code)
	end 2 leith a 27 is er trei		Lisa Washington	/ Daughter			urel Way M			
Baltimore,	of He of He if item or oth		20a. Method of Disposition 12□ Burial 2 □ Cremation 3	Removal from Sta	20b. Place of Disp cemetery, cre	matory or other place	ce) Dat	e 20c.	Location - City or T	Fown, State
Ë	ment tent: tent:		*4 □ Donation 5 □ Other (Spec	ify)	Cemetery		7-18-20		tland MD	
Bal	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other treumatic event, its Medical Exactival must be rediffed at any in.		2) Signature of Funeral Service Rice	n a	ns 20	2. Name and Addre	ss of Facility Pope Ave SE Wasl	Funeral nington D	Home C 20020	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that caus y one cause on each	line.			0 ~		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. CHI		CONAL	FAILLI	RE		
	Examiner			Due to 1	as a consequence of):	ABSCI	55585	•		
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or	as a consequence of):					
	acuted nd transii	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
760,	ate be executed hysicien and the burial-transit	cai Ex	resulting in death) cast	Due to (or	as a consequence of):					
687	ficate physics the b			d						
Вох	leath certificat attending phy I for use as th	In/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor		□Ectopic pregnancy	,		23d. Date of deli	*
	iaw requires thet the death certifica as been signed by the attending ph 2 should be detached for use as th	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		at time of death 5	Other (specify)	′		Month	Day Year
P.0	n requires thet the de been signed by the s should be detached	Ph)	Part II. Dther significant conditions	contributing to deat	but not resulting in the	underlying cause giv	ren in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
Records,	uires n sign uld be	d by	DIABETE	75 M	EWITU	5		1 ☐ Yes	2 □ No 3 □ Pro	obably 4 Onknown
O	aw rec s bee	Completed						24a. Was an autopsy	24b. Were au	topsy findings available
	0 5 0	om						performed		completion of cause of
of Vital	iician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	2		I ou	26. Place of Death (Check only one)		
of \	hys this al di	P	1 Yes 2 No	Hospital: 1 Inpa		and the second second	4 Lanursing Home	5 Residence d. Describe how in	6 ☐Other (Spec	eify)
O	Ter Ter	tion	1 Natural 5 Pending 2 Accident investigati	28a. Date of I (Month,	Day Year) Injury	Wo	rk? Yes 2 No	a. 2000/120 11011 111	july coodinou	
Division	Attending ir death.	ifica	3 Suicide 6 Could not	be 28e. Place of	Injury - At home, farm, s etc. (Specify)	treet, factory, office	28	f. Location (Street City or Town, St	and Number or Ru	ral Route Number,
Ö	tel or rs efte el Dir	Certification:	4 - Hornicide	building,	etc. (Specify)			Only of Town, on		
	To the Hospitel or Attendir within 24 hours efter death. To the Funerel Director: Al completely filled in by the fu	edicai			st of my knowledge, dea s of examination and/or i stated.					
	To th withir To th	Me	29b. Signature and title of certifier	1/1	n H	29c. Licens	se number	29d. I	Date signed (Month	Day, Year)
•	(in)		- Contoine	Kolo	aug Ilil	1 1.	55750	14	127 07,	6009
O_	(10)		612/MONTR	050 QU	AD, KO	CKV12	LE, F	10 2	085	2005
	Sta Regist		31. Date filed (Month, Day, Year) JUL 1 8 2005	32. Reg	strar's Signáture	<i>U</i>				

with the Maryland

Baltimore,

Physician /Medical Examiner requires that the death certificate be executed burial-transit ettending physician and for use as the burial-trar use as the the has

filed withIn 72 hours after death Hygiene. is marked other t and 2 should be fealth and Mental permit. Pages 1 and 2 Department of Health a Importent: if item 27 is any injury or other treu QDC8. Records, P.O. Box 68760. this certificate Division of Vital Hospitel or Attending Physicien: 44 hours after death. Funerei Director: After this certifice within 24 hours a To the Funerei I

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 8:40 AM FRANCIS MARLAND WATERS, JR. July 17 2005 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Talbot Genesis HealthCare - The Pines Easton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JULY 10 1919 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 M 2 ☐ F **Funeral** Months Days Hours MASS 86 121-05-8177 Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10h County r than "natural", or items 23a or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes XX No Director EASTON MD TALBOT 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21601 29369 WOODRIDGE DRIVE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify: Specify: WHITE þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) MAGAZINE EDITOR 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) GRACE ALDEN FRANCIS M. WATERS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3371 N. CALLE DE CATALINA, TUCSON, AZ 85749 CHRISTOPHER A. WATERS/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State CREMATORY OF DELMARVA 7-18-2005 DELMAR, DE ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST EASTON, MD 21601 21. Signature of Funeral Service Licensee m. Ostrousk c.f.S.P. Joseph 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death End-stage renal faiture Immediate Cause (Final years disease or condition resulting in death) ence of): herosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ obstructive pulmonory 3 Probably 1 □ Yes 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending 2 No 1 Yes investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 610 (ROW) 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 1 9 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				For State Registrar	State	of Marylan		irtment of F	lealth and I Death	Mental H	ygiene Reg. No	2000	25072
		Physici	an	1. Decedent's Name (First, Middle						2. Date of D Month			3. Time of Death
		/Medic	al	Charles Frank1 4a. Facility Name (If not institution				4h City Town o	r Location of Death		40	County of Death	10201
		Examin	er	Doctor's Commun	-			Lanham				ince Geo	rge's
		Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B	irth	9. Birthp	lace (State or Foreign
		Director		051-16-9725	1 X M 2□ F	8	5 Yrs.			July .	30, 1	919 New Y	/ork
		and and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
		the Marylar 28a-f show	tor	Maryland Prince	George's	Bow	ie						1X Yes 2 ☐ No
		h the	Director	10e. Street and Number				10f. Zip Code			10g. Cit	izen of What Coun	itry?
		death with the Maryland ms 23a or 28a-f show rriust ke nutified at	raiD	3800 Enfield Ch				20716			USA	44.8 4	- Indian
		er des items	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Marr	Amed F	cedent Ever in U. forces? 2 \(\text{No} \)	.S. 13. \	Was Decedent of H f Yes, specify Cuba	Hispanic Origin? (S an, Mexican, Puert	o Rican, etc.)	10-	14. Race - Americ Black, White,	etc.
1	36	hours after tural', or ite al Evamine	by F	3 XWidowed 4 □ Divorced	If Yes, G Year or	Dates:1941-	45	1⊡ Yes 2⊡XNo	Specify:			Specify: Whit	e
12, ght	2-0	72 hor natura	Completed	15. Deceden (Specify only highes	t's Education	1)	(Give	dent's Usual Occup	during most of wor	rking	16b. K	ind of Business/Ind	dustry
of.	2	vithin ne. han "	mpi	Elementary/Secondary (0-12)	College	(1-4or 5+)	life.	DO NOT use retired Technolog	d)		Fed	leral Gov	ernment
2	42	filed within 72 Hygiene. other than "nai ent, the Medic		17. Father's Name (First, Middle,	Last)		roou	Technoro	18. Mother's Nar	me (First, Middi			
3	lan	Mental rked o	To Be	Charles Wright					Ellen So	chellin;	g		
VY	ary	should thankand Menter sharked	-	19a. Informant's Name/Relations	hip (Type, Print)	estic	19b. Mailir	ng Address (Street	and Number or Ru	ıral Route Num	ber, City	or Town, State, Zip	Code)
76	Σ,	s 1 and 2 if Health a item 27 is other trai		Lorraine W. Col	lins/	tner	3800	Enfield	Chase Ct		Bowie	ocation - City or To	16
harles	Baltimore, Maryland 21215-0036	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at Once.		20a. Method of Disposition 1 □ Burial 2XXCremation		n State		sition (Name of natory or other place		L [©] 419, 005		nton, Mar	
7	ţ	it. Pa rtmen rtant: njury		 4 □ Donation 5 □ Other (S 21. Signature of Funeral Service. 		W •		1 Cremate					
V	Ba	Departing Departing Important Income.		Boselut	Holth	L MO						P.O.Box	784 • MD 21029
				23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the deat	h. Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory	arrest,		Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition		50	P91	5					Onset and Death
		/Medical Examiner		resulting in death)	Due to	o (or as a conseq	ence of):	2 /2	la an cuo			~ C 10	1000
			<u></u>	Sequentially list conditions,	b. Due to	1465+	(uen e of):	1 110	MUCY	CIVID	MU	of li	V CT
		uted	Examiner	Sequentially its conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	S								
	0,	an an		resulting in death) Last	Due to	o (or as a conseq	uence of):						
	8760,	cate be executed by sician and the burial-transit	dicai		d								
	9 X	leath certifica attending ph I for use as th	Physician/Medical	IF FEMALE:	23c. If yes, o	utcome of pregna	ancy					23d. Date of delive	erv
	Вох	death a atter d for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pre	birth 2☐Feta gnant at time of c]Ectopic pregnanc] Other <i>(specify)</i> _	y			Month	Day Year
	P.O.	that the de led by the a detached f	hys	9 Unknown	9□ Unk	nown							
	Division of Vital Records, F	sign sign d be	by	Part II. Other significant condition	ons contributing to	death but not res	sulting in the u	nderlying cause giv	ven in Part I.		tobacco Yes 2	use contribute to the	^
	900	law requase been	Completed							24a. Wa	topsy	prior to co	psy findings available mpletion of cause of
	E B		Con							1 ☐ Yes	formed? 25 No	death?	2 / No
	Vita	ysician: ils certific director,	o Be	25. Was case referred to medical examiner?	Hospital:	Z man	ER/Outpatie	Oti	26. Place of De			6 □Other (Specif	5.1
	of	Jing Phys	 	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Dat	Impatient 2 of Injury onth, Day Year)	28b. Time o	f 28c. Inju	4 🗆 I (disiligi	28d. Describ	_		y/
	ion	death. ctor: After y the funer	atio	1 Natural 5 Pendir 2 Accident investi	gation	omm, Day rear)	Injury		Yes 2 No				
	ivis	or Atterderinecto	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be nined 28e. Pla buil	ce of Injury - At h Iding, etc. <i>(Speci</i>	ome, farm, st	reet, factory, office			(Street al own, State	nd Number or Rura e)	il Route Number,
		pital c		29a. Certifier 1 Certifyin	ng Physician: To t	he heet of my kni	wledge dest	h occurred at the ti	ime, date and place	e and due to th	ne cause/s	and manner as s	tated
		To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director.	edical	(Check only 2 Medical one)	Examiner: On the	basis of examina anner stated.	ation and/or in	vestigation, in my	opinion, death occ	urred at the time	e, date an	d place, and due to	the cause(s)
		To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certifie	1001	00		29c. Licen:	se number	121	29d. Da	ate signed (Month,	Day, Year)
				1	10	5		1	147	++1		115	105
6	+1	02		30. Name and address of person	who completed ca	use of death (Ite	m 23a) (Type.	Print)	100-to	208	Cn	mnois	at Hoa
(1	1	St.	ate	31. Date filed (Month, Day, Year,		Resistrar's Sign			10010		_ V.	11111	17 1100
		Regist		JUL 1	9 2005	Hiero	K A	barte					

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2ੴ5 July **Physician** Jeffery Lewis Young 7:00 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Clinton Prince George's Southern Maryland Hospital If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Months 10XM 2□ F Director Sep. 3, 1972 Wash. DC 578-13-8240 Usual Residence of Deceden with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State in than "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at 1 TYYes 2 □ No DC Washington Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a appringing or other traumatic event, Ita Medical Exercited PRES. 1356 Emerald St., N.E. 20002 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married ☐Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify **Black** þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Student Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Arnold Young Jacqueline Speed 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Raymond C. Bland - Cousin 3906 Cotton Tree Lane, Burtonsville, MD 20866 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State * 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Cem. 7/16/05 Suitland, MD 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service Licensee ework 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of Division of Vital Records, P.O. Box 68760 Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) the 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 | Yes 2 | No 3 | Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy 2 No 1 Yes the Hospital or Attending Physician: Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death After Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 | Homicide filled e Funeral 29a Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medi Vithin 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 07-09-2005 D45365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Sidarous, M.O 170/livingston Rd #10/fthashington MD 2076 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 1 8 2005 Registrar

	•	a K	For State Registrar			State of	of Maryla					and Me	ental Hy				0.000
	٠			ne (First, Mide	dle, Last)								2. Date of Do Month	Da	y Y	ear ear	3. Time of Death
	Physicia /Medic	al								-	4 4'	4 Death	July				2:32 A. M
}	Examin	er							4b. City,					40			aton
	Funeral		5. Social Security		6. Sex			s. last birthday)		1 Year	If Under	24 Hrs.	8. Date of Bi	irth	9	Birthp	place (State or Foreign
	Funeral Director		215-18-1	593	1 🗆	м Ж] F	83	Yrs.	Months	Days	Hours	MIn.	June 1	5,19	22 N		
	pu k		Usual Residence		tv		10c. C	City, Town or Lo	ocation	-				-			10d. Inside City Limits
	Maryla f sho	ō	Md.			gton		Sm	ithsbu	ırg							1 ☐ Yes 2 ☐ No
	r 28a-	irect	10e. Street and N	umber					10f. Zip					10g. Ci			ntry?
	th with	al D	P.O. B	ox 127													
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Heath and Mental Hygiene. Important: If item 27 le marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinat must be notified at once.	by Funeral Director		rried 2□ Ma	arried	Armed F 1 Tes If Yes, G	orces? 2[X No ive				spanic Ori n, Mexicar Specify:		cify Yes or N Rican, etc.)	0-		White,	
ò	2 hou	ted	/90	15. Decede	ent's Educ	ation	1	16a. Dece	dent's Usua	I Occupa	ation during mos	t of working	na	16b. K	and of Busin	ess/in	dustry
21215-0036	ithin 7 ne.	Completed by						life.					.9	St	ate Go	Me.	rnment
	illed w Hygier thar th									, al		er's Name	(First, Middle	1 -			
lau(ld be i ental I kad o	То Ве			. ,							Cl	harlot	te D	renne	r	
Maryland	2 shou and M Ie mar aumat	-							•								Code)
	1 and 1ealth am 27 thar tr				ght (Siste		Place of Disp	osition (Nar	ne of				, -			own. State
Baltimore,	ages ant of h it: If its y or of		1 🔀 Burial	2 Cremation		emoval fron		cemetery, cre	matory or o	ther plac	e) Park					•	
alti-	mit. Poartme					90	1	2	2. Name an	d Addres	s of Facili			1			
ä	Dermi Depa Impo any ir		-	10	DA	Jis.							Iome Sn	niths			21783
i i	Physician		shock, or he Immediate Cause disease or condi	eart failure. Li e (Final tion	or complicing ist only on	e cause on	each line.		ter the mod	e of dyin	g, such as	cardiac o	r respiratory	arrest,			Approximate Interval Between Onset and Death Chronic
	/Medical Examiner		resulting in death	1)		Due to	o (or as a conse	equence of):									
in the	p #.	iner	Sequentially list of any, leading to cause. Enter Uni	conditions, immediate derlying	J ^b	Due to	o (or as a conse	equence of):									
4	cate be executed physician and the burial-transit	Examiner	that initiated ever resulting in death	or injury nts	c	Due to	o (or as a conse	equence of):								+	
8760,	e be e rsician e buria	calE			L.	l											
9	tificate ng phy as the	ed	15.55111.5								-						
.O. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/M	in the past	12 months? 2 ☑ No	2:	1☐Live 4☐Pre	birth 2 Fe	etal death 3									ery Day Year
4	n requires that been signed b should be deta	by	Part II, Other sign	nificant cond	itions con	ntributing to	death but not re	esulting in the u	underlying o	ause giv	en in Part I	l. 					
Records,	9 ~ 9	Completed	-	A. A. Young A. Young A. Cay, Town or Location of Death A. County	opsy findings available ompletion of cause of												
Vital	Physician: Th this certificate ral director, pag	Be (25. Was case ref	ferred to medi		loopital:				Oth							ASSISTANT
of	hys this	. To	1 Yes 2			28a. Dat	e of Injury	28b. Time o		JA	4 📙 NI					(Speci	ty) Living,
ion	nding F ath. r: After e funera	ation	1 Natural 2 ☐ Accident			(Mo	onth, Day Year)	Injury]No					
Division	al or Attending s after death. Il Diractor: Afte id in by the fune	Certification;	3 Suicide 4 Homicid	data		28e. Plac buil	ce of Injury - At ding, etc. <i>(Spe</i>	home, farm, si	treet, factor	y, office		2				or Rur	al Route Number,
	To tha Hospital o within 24 hours af To tha Funaral D completely filled in	edicai (29a. Certifier (Check only one)	1 Certif	al Examir	ner: On the	basis of exami	nation and/or in	nvestigation	, in my o	pinion, dea	ath occurre	ed at the time	e cause(s e, date ar	s) and mann nd place, and	er as s d due t	stated. to the cause(s)
	To the within To the comp	×	29b. Signature a	nd title of cert	neitier	-	-		29	c. Licens	e number			29d. D	ate signed (
	ī		P		7			95.1		V O C	162	113		7	128/	0.0	•
_	- V		30. Name and ac	^	on who po	mpleted ca	use of death (It	L Sd cg	t, t	tage	ersto	WN, r	W.				
·[0	Sta Regist		31. Date filed (M	onth, Day, Ye	ar) 2005	Be	use of death (III	ature for	May 1	V							
						- 2											

		ľ	1 - For Stata Registrar	State of I	Maryland		artment rtificate			and Me	ental Hy	giene	105	25076
	14	A No.	Decedent's Name (First, Middle,	Last)					-		2. Date of De	ath	200	3. Time of Death
4	Physici		Mary Doris	Auer							Month July	Day 31	Year 2005	11:35P. M
	/Medic Examin		4a. Facility Name (If not institution,		er)		4b. City, T	Town, or	Location of			4c. Co	ounty of Death	
		1	Bon Secours Prov	incial Ho	use		Marr	iott	svil	1e		Н	oward	
- 2	Funeral				Age (In yrs. las		If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Bit (Month, Da	rth ay, Year)	9. Birth Cou	place (State or Foreign intry)
ш	Director		215-14-0279	1 L M 2 E F	83	Yrs.					May 4,	1922_	Mar	yland
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
	faryli	ō	Marrian I Harrana	1		M	_ 4-4							1 ☐ Yes 2 No
	28a-	Director	Maryland Howard	1		Marri	Ottsv					10g. Citize	n of What Cou	intry?
	with E or	Ö	1525 Marriotts	ville Road				2110	1/4			II	.S.A.	
	ns 23	Funerai	11. Marital Status	12. Was Decede	nt Ever in U.S.	. 13.				gin? (Spec	cify Yes or No tican, etc.)		Race - Amer	
(0	r lter		1 X Never Married 2 ☐ Marrie	Armed Force						n, Puerto F	tican, etc.)	1	Black, White	, etc.
93	ral', c	l by	3 Widowed 4 Divorced	If Yes, Give Year or Date	s:		1 ☐ Yes 2	(K) 140	эреспу.			54	wh	ite
21215-0036	in 72 hours after death with the Maryland "netural", or Items 23c or 28e-f show edical Etter in trivial Le Indithed at	Completed	15. Decedent's (Specify only highest			(Give	dent's Usua kind of wor	k done o	furina mos	t of workin	g	16b. Kind	of Business/I	ndustry
21	C * D	mpi	Elementary/Secondary (0-12)	College (1-4			DO NOT us						-	
7	be filed withi		17. Father's Name (First, Middle, L.	5+		Catho	lic N	un N		r's Name	(First, Middle	Medi		
and		Be									et War		imamoj	
ž	2 should be and Mental Is marked aumailc ev	2	Bernard Ceci			19h Mailir	na Address	(Street a					own, State, Z	in Code)
Maryland	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		Sister Elaine Da		ter)									MD 21104
	ges 1 and tof Health If item 27 or other tr		20a. Method of Disposition	(515	20b. Pla	ce of Dispo	sition (Nam	e of	- "		ate		tion - City or 1	
noi	0 0		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		ite	netery, crer Cathe				8-4-2	005	Balti	more.	Maryland
Baltimore,	artin orte inju		21. Signature of Funeral Service Li	-				-	4 .				lle, I	
B	Departing Department of the policy of the po		> Klibice X	· Hera	<i>></i>	16	.tzke 30 Ed	mond	lson A	Ave.	or Cat Catons	onsvi ville	Mary	nc. land 21228
	•		23a. Part 1. Enter the disease, or c shock, or heart failure. List of	omplications that causely one cause on each	sed the death.	Do not ent	er the mode	of dying	g, such as	cardiac or	respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	.,	/1	in d	in	nel	ale	atti	U			Onset and Death
	/Medical		resulting in death)	Due to (or	as a conseque	ence of):					Jn	\ .		
	Examiner		Sequentially list conditions.	b	COY	ma	14	0	ute	ery	Oll	Leo	se	
	pe tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseque	ence of):	J							
	and I-trans	xam	that initiated events resulting in death) Last	c	as a conseque	ance of):								
8760,	ate be executed physician and the burial-transit													
687	certificate be executed nding physician and use as the burial-transit	Physiclan/Medical		d										
Box (death certifica attending ph d for use as th	/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			3					230	d. Date of deli	very
m		icla	in the past 12 months?	4□Pregnan	n 2 ☐ Fetal d t at time of dea		Ectopic pre Other (spe						Month	Day Year
0	t the	hys	9 🗆 Unknown	9Ll Unknow	n 									
s, P	w requires that been signed to should be det	ру Р	Part II. Other significant condition	s contributing to deat	h but not result	ting in the u	nderlying ca	ause give	en in Part I	•		_		the cause of death?
Records,	requires leen sign hould be		Diavell	5 190	llil	lis					1	Yes 2	No 3∐Pro	bably 4 Unknown
ecc	2 2 2	pie									24a. Was	DSV	prior to c	topsy findings available ompletion of cause of
<u> </u>	ate pag	Completed									1 Yes	ormed? 2-D No	death?	2□ No
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only			
of	d 55	70	1 Yes 2 No 27. Manner of Death	28a. Date of I		R/Outpatier 28b. Time of			4 🗆 190		e 5 Res 8d. Describe		Other (Spec	ify)
L C	ding f	ion	1 Natural 5 ☐ Pending	(Month,	Day Year)	Injury	м	8c. Injury Work	k? Yes 2□	i	04. 500050			
Division	or Attending after death. Director: After in by the fune	fical	3 Suicide 6 Could no	ot be 28e. Place of	Injury - At hom	ne, farm, str							lumber or Ru	ral Route Number,
Ω	after after Direct	Certification;	4 Homicide	building.	, etc."(Specity)						City or To	wп, State)		
	e Hospitel 24 hours a e Funeral (sai C	29a. Certifier Charles and Continued to the continued to	Physician: To the be	est of my knowl	ledge, deati	occurred a	at the tim	ne, date an	d place, a	nd due to the	cause(s) ar	id manner as	stated.
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	one)	xaminar: On the basi and manner	stated.	ni anuvor in				wi occurre	at the time,			
	To the within 2.	Σ	29b. Signature and title of certifier	~				-	number)		0/	signed (Month	, Day, Year)
•	A		1 T. Kalis	Derps				25	110			81	100	22
	3		30. Name and address of person w	- Idaha	of death (Item 2	23a) (Type,	Print)	191	ls ld	Y 5	sult	0 10	:100	MD2111/
			31. Date filed (Month, Day, Year)	32. Reg	istrar's Signatu	re /	1 5 1 1				Lin	ysm	400	
	Sta Registr		AUG 0 2 200	Mother	istrar's Signatu	Apade						J		

Second Second Provided Sec			For State Registrar	State of Maryland		rtment of H tificate of L		⁄lental Hygie Reg	ne n2005	25077
Security Number As Earth, Nu		_		d Applegat	e			Month	•	3. Time of Death 11:10 P
The control of the				treet and number)			Location of Death		4c. County of Dea	ith
The control of the			148-34-4698					(Month, Day, Ye	ear) C	rthplace (State or Foreig ountry) ristown, Ni
17. Father's Name (First, Middle, Last) 19. Mailing Address (Street and Number or Natural Route Number, City or Town, State, Zip Code) 19. Mailing Address (Street and Number or Natural Route Number, City or Town, State, Zip Code) 19. Mailing Address (Street and Number or Natural Route Number, City or Town, State, Zip Code) 19. Mailing Address (Street and Number or Natural Route Number, City or Town, State, Zip Code) 19. Mailing Address (Street Elkridge, MD 21075	Maryland -f show	tor	10a. State 10b. County			cation				10d. Inside City Limits
17. Father's Name (First, Middle, Laxt) 18. Middle, Marker (First, Middle, Marker Name (First,	with the 3s or 26s	Il Direc		Street			5	-		
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maken Surname) 18. Mother's	urs after death	þ	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes. Give				pecify Yes or No- Rican, etc.)	Black, Wh	ite, etc.
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Madden Surname) 18. Mother's Name of N	within 72 hou ane. then "natura ne Madical E	mpleted	(Specify only highest grade	College (1-4or 5+)	(Give life. L	kind of work done o DO NOT use retired	furing most of work)	king		,
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest, interest caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest, interest caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest, interest caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest. Interest cause final interest cause interest cause final interest cause interest cause interest cause interest cause final interest cause interest cause interest cause interest cause interest cause interest cause ca	uld be filed wental Hygienrice other itic event.	Be					18. Mother's Nam Olive	e (First, Middle, Mai Pearson	iden Sumame)	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest, interest causes of reach lear. It is continued to cause of reach lear interest causes of reach lear interest causes. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest, interest causes interest causes. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest. Interest causes interest causes. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest. Interest causes interest causes. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest. Interest causes interest causes. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest. Interest causes interest. Interest causes interest causes interest. In the cause interest causes in the cause of causes in the cause of causes. Entered the death. Do not enter the mode of dying, such as cardiac or respiratory arest. In the cause of causes of each lear. In the cause of causes of causes of causes of causes. Entered the death. Do not enter the mode of dying, such as cardiac or respiratory are sufficient. In the cause of causes of causes of each lear. In the cause of causes of causes of causes. In the cause of causes of causes of causes. In the cause of causes of causes of causes. In the cause of causes of causes. In the cause of causes of causes. In the cause of causes of causes of causes. In the cause of causes of causes. In the cause of causes of causes of causes. In the cause of causes of causes of causes of cau	and 2 sho ealth and I m 27 is ma		Elaine Denise App	legate/ spouse	6421	Sedgwick	Street :	Elkridge,	MD 21075	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest, interest of cause of neath interest of cause (Pina) interest of cause	Pages 1 tment of H tent: if iter ijury or oth		1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State Denv	emetery, cren 7ille (natory or other plac Cemetery	8/4			
a shock or heart failure. List only one cause on each line. Medical Examiner Medical	Depar Impor eny in		> Affile	M01213	3	naldson 13 Talbot	Funeral t Ave. L			Approximate
FEMALE: 23b. Was decedent pregnant 1 Live birth 2 Fertal death 4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery Month Day	/Medical Examiner uysicien and perial-transit	ical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Erries underlying Cause (Disease or injury that initiated events	Esophageal Due to (or as a consequ Due to (or as a consequ	uence of):	ancer				Onset and Death
1 Yes 2 No 3 Probably 4	death certific e attending p od for use as	ysician/Med	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal	death 3					
24a. Were autopsy inclined autopsy inclined autopsy inclined autopsy performed? 25. Was case referred to medical examiner? 1	90 00	by	Part II. Other significant conditions cor	tributing to death but not resu	ulting in the u	nderlying cause give	en in Part I.			to the cause of death? Probably 4 XUnknov
25. Was case referred to medical examiner?	The law ate has b page 2 si	Complete						autopsy performe	d? prior to	completion of cause o
29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year D45217 29d. Date signed (Month, Day, Year D45217	ding Phys h. After this funeral di	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	1 Inpatient 2 1	28b. Time of	28c. injun Worl	er: 4⊈ Nursing H y at k?	ome 5 Residence		ecify)
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year D45217 29d. Date signed (Month, Day, Year D45217	al or Atten s after deat af Director: ad in by the	Certifica	3 Suicide 6 Could not be	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str	eet, factory, office				Rural Route Number,
D45217 8/1/2005	the Hospit in 24 hour the Funere	edical	(Check only 2 Medical Exami	ner: On the basis of examinat		vestigation, in my o	pinion, death occu	rred at the time, date	and place, and du	e to the cause(s)
	To T Com	Σ)	1 m	/	D452	17			un, Day, Tear)
30. Name and address of person who complete, o use of death m 23a) (Type, Print) Adebowale Ajayi 501 Grenbelt Road Suite 415 College Park, MD State Registrar AUG 0 2 2005	10			11 2			415 Col	lege Park	, MD	

	4990		1 - State Amend Item	State of Maryla 1 per me G846	and / Depa 8-2-05 8-2-06	artment of He tificate of D	ealth and M Death	lental Hyg	giene Rog. No 2005	25078
4	Physici	an	1. Decedent's Name (First, Middle, La			D 6:	-1-3	2. Date of Dea Month July 2		3. Time of Death
1	/Medic	al	Aaron 4a. Facility Name (If not institution, gir	Graham		Benefi. 4b. City, Town, or L		July 2	4c. County of Death	10:04 A ^M
1.	Examin	er	Johns Hopkins Ho			Baltimon			NA	
5	Funeral Director		5. Social Security Number 6. 212–13–0026	Sex 7. Age (In y. 12	rs. iast birthday) Yrs.	If Under 1 Year Months Days	If Under 4 Hrs. Hours Min.	8. Date of Birtl (Month, Day 1-20-	9. Birth (, Year) Con	nplace (State or Foreign untry) Md.
	pud *		Usual Residence of Decedent 10a, State 10b, County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Maryla	lor	Md. NA		•	imore				XXYes 2 □ No
	r 28s	Director	10e. Street and Number			10f. Zip Code	-		10g. Citizen of What Cou	untry?
	23a o	raiD	823 N. Caroline			2120			USA	
21215-0036	be liled within 72 hours after death with the Maryland ital Hyglene. od other than "neturel", or items 23s or 28s-f show event, the Modical Examinat must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 21 No If Yes, Give Year or Dates:	1	Was Decedent of His f Yes, specify Cuban 1 ☐ Yes	panic Origin? (Sp., Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: B1	e, etc.
5-0	72 hc	eted	15. Decedent's E (Specify only highest gi		16a. Deced (Give	dent's Usual Occupat kind of work done du DO NOT use retired)	ion iring most of work	ing	16b. Kind of Business/I	ndustry
121	within ene. than	Completed	Elementary/Secondary (0-12) 9th grade	College (1-4or 5+)		ishwasher			Overlea Ca	terier
id 2	should be filed within and Mental Hygiene. ie marked other than aumatic event, Ine Man	Be Co	17. Father's Name (First, Middle, Las	t)			18. Mother's Name	e (First, Middle,	Maiden Sumame)	
ylar	should be fand Mental be marked of	To B	Oliver	Benefi	eld, Jr		Julia		Graham	
Maryland	s 1 and 2 should f Health and Men item 27 ie merke other traumetic		19a. Informant's Name/Relationship			•			or, City or Town, State, Z imore, Md.	ip Code) 21205
	1 and Health tem 27		Julia Benefield 20a. Method of Disposition	Mother 200	1	isition (Name of natory or other place)		Date Dail	20c. Location - City or	
E O	Pages nent of I int: if it		Burial 2 Cremation 3 4 Donation 5 Other (Spec	_Hemoval from State	Parkwoo		7-28	3-05	Baltimore,	Md.
Baltimore,	permit. Pages 1 and 2. Department of Health as important: if item 27 is eny injury or other trau		21. Signature of Funeral Service Lice	ensee Age	22	Name and Address March F.F			more, Md. E. North Av	21202 e.
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	inplications that caused the devone cause on each line.	eath on not ent	er the mode of dying.	, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
).	Physician		Immediate Cause (Final disease or condition	· /	not W	ound of	TOVS	0		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):					
	4	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a cons	sequence of):					
	ate be executed thy sician and the burial-transit	Examiner	Cause. Enter Onderlying Cause (Disease or injury that infliated events resulting in death) Last	c						
8760,	be exe cian a curial-	E	resulting in death) cast	Due to (or as a cons	sequence of):					
687	ficate physi s the t	edical		d						
O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
<u>α</u>	igned by be detac	by Ph	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause giver	n in Part I.		obacco use contribute to	
ord	w require been si should t	ted						1 U Y		
of Vital Records,		Completed						1 XYes	rmed? prior to death?	topsy findings available completion of cause of
Vit		To Be	25. Was case referred to medical examiner? 1∑ Yes 2 □ No	Hospital:	ER/Outpatier	Other	26. Place of Deat		ne) dence 6 □Other <i>(Spe</i> d	(ifv)
JO L	g Physical dispersal di		27. Manner of Death	28a. Date of Injury (Month, Day Year	28b. Time o				now injury occurred	
sior	ttendin death. ctor: Aft y the fur	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not	on 7/22/05	3:30		es 212No	5 U	loject sh.	ot
Division	ni or Attending P after death. i Director: After t d in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not determine	building, etc. (Spe	ecify)		di m	28f. Location (5 City or Tow	Street and Number or Ru vn, State) 3103 (-a	IWN VIEW
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	edicai Ce	29a. Certifier 1 Certifying F	Physician: To the best of my aminer: On the basis of exam and manner stated.	knowledge, deat	h occurred at the time	e, date and place, nion, death occur	and due to the cred at the time,	cause(s) and manner as date and place, and due	stated.
	To the To the comple	Med	29b. Signature and title of certifier	1400-	, jA ,	29c. License		1	29d. Date signed (Month) July 23, 20	
1	37		30. Name and address of person who	o completed cause of death (Item 23a) (Type,	Print)				
-			CHROLHA	ZLAWN	6	111 Per	nn Street	Balti	more, Maryl	and 21201
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar Si	gnature	Goods				
5 -	, region	en e	AUG	0 S TOO2 180	The same of the sa					

		1	For State	•	Department of Health and I Certificate of Death	Mental Hygiene Rag. No	2005 05070
I	Physicia /Medic	an	1. Decedent's Name (First, Middle, Las Alice Aris) /	enski	2. Date of Death Month Da	3. Time of Death Z
	Examin	er	4a. Facility Name (If not institution, give	1 Rd.	4b. City, Town, or Location of Death Pasadena Inday) If Under 1 Year If Under 24 Hrs.	1	C. County of Death Anne Arunde / Co
l.	Funeral Director		5. Social Security Number 6. Sec. 212-36-1455 1	The Adde	Yrs. Months Days Hours Min.	8. Date of Birth	9. Birthplace (State or Foreign Guntry) 9. Birthplace (State or Foreign Guntry) 9. Birthplace (State or Foreign Guntry)
	e Maryland la-f ehow liffed al	ctor	Maryland Anne	Arundel Pas	n or Location Cadena		10d. Inside City Limits 1 ☐ Yes 22 No
	ath with the 23e or 26	Funeral Director	10e. Street and Number 1262 Rockh	11 Rd.	10f. Zip Code 2//22	6	itizen of What Country? 1. A A A A A A A A A A A A A A A A A A A
036	urs after de ai', or iteme Exemenar u	þ	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 27 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, White, etc. Specify: White
21215-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hyglene. ortant: if item 27 ie marked other than "natural", or iteme 23a or 28a-f ehow injury or other traumatic event. The Ms.dical Examples institled at injury or other traumatic event. The Ms.dical Examples institled at 8.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0·12)		Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)		Computers
	buld be filed went and the street of the street of the street of the street aftic event, the street of the street	To Be Co	17. Father's Name (First, Middle, Last) John Mu	ller	18. Mother's Nar	ne (First, Middle, Maide Kein	
, Maryland	and 2 should ealth and Mer m 27 ie marke her traumatic		19a. Informant's Name/Relationship (1) Mr. Robert L	. Bordenski, pr	Mailing Address (Street and Number or Ru	Rd. Pasa	rdena, MD, 21122
Baitimore,	permit. Pages 1 Department of He important: if iter any injury or oth once.		20a. Method of Disposition 128urial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State Camete	Disposition (Name of ry, crematory prother place) A Management of the place of the	Date 2005 1, 1, 2005	Tomonium, MD,
Bai	permit. Pag Department important: any injury once.		21. Signature of Funeral Service Licen	J. Jan, Se	Peacety fork	narves h	nium, MD: 21093
	Pnysician /Medical		23a. Part. Stretched issease, of composition of the	a. Due to (or as a consequence	not enter the mode of dying, such as cardia. Once	c or respiratory arrest,	Approximate Interval Between Onset and Death 2 - 5
2,7	icate be executed physician and sthe burial-transit	Examiner	Sequentially list conditions, if any, learning to immodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence Due to (or as a consequence)			
68760	tificate be ng physicia as the bur			d			
.O. Box	death cer e attendir id for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
٥.	ss that th gned by se detac	by	Part II. Other significant conditions of	ontributing to death but not resulting i	n the underlying cause given in Part f.	23e. Did tobacco	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
of Vital Records,	The law ate has b page 2 sl	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
/ita	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?	11		ath (Check only one)	
£	S S E	은	1 Yes 2 70	Hospital: 1 Inpatient 2 ER/O		lome 5 Residence	
Division (ding h. After fune	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	(Month, Day Year)	Time of Injury at Injury Mork? M 1 Yes 2 No	28d. Describe how inj	and Number or Rural Route Number,
Divi	in Signature		4 Homicide determined	building, etc. (Specify)	, and the second	City or Town, Sta	te)
	To the Hospital within 24 hours a To the Funeral completely filled	Aedical	(Check only 2 Medical Exar		e, death occurred at the time, date and place d/or investigation, in my opinion, death occurred ticense number.	urred at the time, date a	
}	To viti	Σ	29b. Signature and title of certifier	har	29c. License number D39505 (Type, Print) HOSPITAL D. G.		
	1.2		30. Name and address of person who	completed cause of death (Item 23a)	(Type, Print) Hospital M. G.	lan Burn	- 4 MD 21061

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Reg. No.2005 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** BowlEy JUSEPH 07 OS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NURSING HOME MARINER Prince George Laurel If Under 24 Hrs. Hours | Min. 8. Date of Birth (Month, Day) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2□ F Months West Virginia 232-26-2295 Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10b County or 28e-f show of Health and Mental Hygiene.
Item 27 Is marked other then "natural", or Items 23e or 28e-4 show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Prince George 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5900 Parkway Drive 20707 U.S.A. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1941-45 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married → Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Journeyman Printing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Veronica Yaklin Theodore H. Bowley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5900 Parkway Drive, Laurel, MD 20707 Zita Bowley /spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ivy Hill Cemetery Aug 1 Laurel, Maryland 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee M00773 313 Talbott Ave. Laurel, Maryland 20707-4389 Part Enter holispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or lear failure. List only one cause on each line. Physician CARCINOMA OF STOMACH Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): METASTASIS TO PANCREASE AND. Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, 🔦 Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobscco use contribute to the cause of desth? PARKINSON'S DISEASE. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of beatin? HYPERTENSION 24a. Was an autopsy performed? CEREBROVASCULAR ACCIDENT 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other:

Nursing Home 5 □ Residence 6 □ Other (Specify) 10 1 ☐ Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 Yes 2 No Director: A 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours of To the Funerel D completely filled is edical 1 Certifying Physicisn: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifie D 21294 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABDUL NAYEEMIM.D. 3450. FORT MEADE ROAD, SUITE 100, LAUREL, MD 20724 31. Date filed (Month, Day, Year) Registrar's Signature AUG 0 2 2005 Registrar

			For State Registrar	State of M	larylan	-	artmen rtificate			and M	lental Hy	giene Reg. N2 0 (05	25081
	Physici	an	1. Decedent's Name (First, Middle								2. Date of De. Month	31, Day 200	Year	3. Time of Death 4:35 a M
	/Medic	al	Theodo:	ra Rose Bend			4b. City.	Town, or	Location of	of Death	oury			7.5) a M
	Examin	ier	Carroll Hosp:	. •	,							Ca	rroll	
	Funeral Director		5. Social Security Number 139–09–6287	6. Sex 7. A 1 □ M 2 □ XF	ge (In yrs. 1 89	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird Month, Da July I	7,1916	9. Births Cour New	place (State or Foreign htry) Jersey
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City	/, Town or Lo	cation						1	Od. Inside City Limits
	Mary e-f sh	ctor	Md. Car	roll		Westmi	nste	r						1A Yes 2 No
	th with the 23a or 28	al Director	10e. Street and Number 303 Cold	Stream Clos	se		10f. Zip	21:	158					ntry?
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "neturel", or Items 23a or 28e-f show or other traumatic event, the Madical Examplar must be notified at	by Funeral [11. Marital Status 1 □ Never Married 2 Marr 3 □ Widowed 4 □ Divorced	If Yes, Give	? LNo	l l	Was Deced f Yes, spec 1 Yes		ispanic Ori n, Mexicar Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	Blac	ck, White,	etc.
5-0	72 ho	Completed	15. Deceden (Specify only highe.	t's Education st grade completed)		16a. Deced	dent's Usua kind of wor DO NOT us	rk done c	durina mos	t of worki	ng	16b. Kind of B	usiness/In	dustry
121	e filed within al Hygiene. I other than ' vent, the we	dmo	Elementary/Secondary (0-12)	College (1-4or	5+)		House		,			Homem	aker	
Maryland 21215-0036	ould be filed Mental Hygid arked other atic event, the	To Be C	17. Father's Name (First, Middle, Joseph Ge		ā								ne)	
lary	2 should and Mer Is marke aumatic		19a. Informant's Nama/Relations											
	1 and Health em 27 ither tr		Linda Jewell 20a. Method of Disposition	- Daugnter	20b. P	lace of Dispo	sition (Nan	ne of	-		-			
mor	Pages ent of nt: If it ry or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 □Removal from State pecify)		emetery, crer etro Ci			Aug	. 1,	2005	Baltimo	re, l	id.
Baltimore,	permit. Pages of the Department of the Important: If ite eny injury or ot once.		21. Signature of Funeral Service		2	22	Eckh	ardt	Fune	ral	Chapel,	P.A.	ld. 2	1102
	Medical Examiner he be executed with the pring-transit and the principle a	al Examiner	23a. Part 1. Enter the disease, or shock, or fregit failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, isating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a Due to (or a b Due to (or a control or a control	s a consequence of the consequen	uence of): Le C January: NAG	IS			cardiac c	or respiratory au	rest,		Approximate Interval Between Onset and Death
Box 687	death certificate e attending phy: id for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant	e of pregna 2	ncy	Ectopic pr		r Location of Death nster If Under 24 Hrs. B. Date of Birth Hours Min. July 17, 1916 9. Birthplace Country New Jet 10d. 10	ery Day Year				
ds, P.O.	es that the gned by be detac	by	9 Unknown Part II. Other significant condition	1,000	but not resu	ulting in the u	nderlying c	ause give	en in Part I			obacco use cont res 2 □ No	tribute to th	he cause of death?
of Vital Records,	e law has b	Completed									24a. Was autor perfo	rmed?	Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of
ital	icien: Th certificate ector, pag	Be C	25. Was case referred to medica examiner?	1—1					26. Place	of Death	Check only o			
of V	ys dir	P	1 Tes 2 No	Hospital:	1	ER/Outpatier	-		4 🗀 190	Color Party		dence 6 Oth		y)
on	ling After fune	tlon	1 Natural 5 Pendir	ng (Month, D	ay Year)	Injury	м	8c. Injury Work 1 🔲 '	k? Yes 2□					
Division	= = =	Certification:	3 Suicide 6 Could 4 Homicide determ	lined 288. Place of I	njury - At ho atc. (Specify	ome, farm, str	eet, factory	r, office			28f. Location (S City or Tov		er or Rura	al Route Number,
	To the Hospital c within 24 hours af To the Funerel D completely filled in	edical C		ng Physician: To the bes Examiner: On the basis and manner s	of examinat									
)	To the within To the Comp	Me	29b. Signature and title of certifie	Inova	N	D	1) ~ C			-18		01-	Day, Year) 2005
	/		30 Name and address of person DR. Raman	B. Kaner	19 3°		Print)	lvy	du	u	Nestr	nitriter	MD	21159
	Sta Registi		31. Date filed (Month, Day, Year)	005 Alexander	trans Signa	Jacon Jacon	K)							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2 0 0 5 Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month **Physician** Tuly 10:50 AN 29 2005 /Medical 4b. City. Town, or Location of Deeth 4a Fecility Name (If not institution, give street and number 4c. County of Deeth Examiner Montgomery ar ea/H If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Yeer) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Deys Months Hours 1**⊠**M 2□ F 226-26-3669 Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits tam 27 is marked other than "natural", or flams 23a or 28a-f show other traumetic event, the Medical Examiner must be notified at Prince Georges 1 ☐ Yes 2 No atts Funeral Director Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? SA 20 831 Fairoa 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces r 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: /944 ~ 1946 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Completed by Black 4 Divorced 3 Widowed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Jerk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Maggie arks 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Depertment of Health er important: If itam 27 is any injury or other trau Fairoak Ave. Hyattsville, Maryland 20783 Elizabeth J. Burgess - Wife 831 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8/6/05 Annandale Virginia Pleasant Valley Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. N me and Address of Facility 21. Signature of Funeral Service Licensee hinn Funeral Service 2605 S. Shirlington Read Arlington, Va. 22206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) by Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobecco use contribute to the cause of deeth? 3 Probably 4. Onknown 1 ☐ Yes 2 ☐ No Demer 24b. Were autopsy findings available prior to completion of cause 24a. Wes en autopsy performed? Completed Be edical Certification: To

ettending physicien end for use es the buriel-trensit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, certificate hes b lirector, page 2 s this within 24 hours efter death.

To the Funeral Director; After thi
completely filled in by the funeral

Pages 1 end 2 should be filed within 72 hours efter death with the Merylend nent of Health end Mentel Hygjene. Int: If Itam 27 is marked other than "natural", or Itams 23a or 28a-1 show

3altimore, Maryland 21215-0020

				13 Yes 22No	of death? 1 ☐ Yes 2 ☑ No
25. Was case referred to medical			26. Place of De	ath (Check only one)	
examiner?	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatient 3☐	DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Other	(Specify)
7. Manner of Death 1. Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurre	d
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, street, fact cify)	ory, office	28f. Location (Street and Number City or Town, State)	r or Rural Route Number,
29a. Certifier 2 Certifying Phy	/sician: To the best of my kr	nowledge, death occurre	ed at the time, date and place	e, and due to the cause(s) and man	ner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

D0054566

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

JOSPAROAD Such 230 TOLESON MD 21216 tinitia Bhogaville 140A Ecent 31. Date filed (Month, Day, Year) 32. Registrer's Signature

State Registrar

AUG 0 2 2005



ie i	Darresi	ľ	1 = State Amend Item Amend Item	State of Ma a&Unpend I	aryland/Dep t em 23a &	artment of He Intilicate 1919	ealth and Me fe ac G846	ental Hygie 8-16-05 tas	ene 200	5 2	25083
ik g	Physici /Medic	_	Decedent's Name (First, Middle, La	nst)	de Barresi			2. Date of Death July			3. Time of Death 11:15 A
	Examin	20	4a. Facility Name (If not institution, gi 4900 Governor Ri Ri	ve street and number) e hte Highwa t chie	ay		klyn Park		4c. County of Anne	Arund	
2003	Funeral Director	ā	Social Security Number 6.	Sex 7. Ag 1 ☑ M 2 ☐ F	e (In yrs. last birthday 54 Yrs.		Hours Min.	B. Date of Birth (Month, Day,) July 15,	(°a) 951	9. Birthpla Country New	ce (State or Foreign York
	inyland show		10a. State 10b. County		10c. City, Town or I	_ocation				100	d. Inside City Limits
	the Ma 28a-f	Director	Maryland Anne A	rundel	Baltim			100	g. Citizen of Wh		1 □Yes 2X No
	3a or	Į Dį	4600 - 4th St	reet		10f. Zip Code 2122	25	100	U.S.	iat Country	y :
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: if item 27 is marked other than "natural; or iteme 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:		. Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 ☑ No	panic Origin? (Spec , Mexican, Puerto R Specify:	rify Yes or No- ican, etc.)		Americar White, et Whit	c.
15-0	"natur	ieted	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dec (Giv	edent's Usual Occupati re kind of work done dur DO NOT use retired)	ion ring most of working	9 16	Sb. Kind of Busi	iness/Indu	stry
212	d withingiene.	Be Completed	Elementary/Secondary (0-12)	College (1-4or 5 4 years	Che	mist / Plan	nt Manage	r	Chemical	l Pla	nt
land	uld be file Mental Hyg rked othe	To Be C	17. Father's Name (First, Middle, Las Phi1	ip Barresi		1	8. Mother's Name (First, Middle, Ma dre Nico)	
Baltimore, Maryland 21215-0036	and 2 sho salth and h n 27 is ma er treuma		19a. Informant's Name/Relationship Karen Barresi /			ling Address (Street and - 4th Street		Route Number, (timore,			
imore	Pages 1: nent of He ant: if iten ury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Speci			oosition (Name of ematory or other place) Crematory	7/30/2		oc. Location - C		
Balt	permit. Departr Imports any inju		21. Signature of Funeral Service Lice 23a Part 1. Enter the disease, or coshock, or heart failure. Ust of	ramuse	ishi	22. Name and Address 4001 Ritchi nler the mode of dying,	ie Highway		more, M	lary1a	and 21225
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Narcotio		hol intoxio					nterval Between Onset and Death
	Examiner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	a consequence of):					+	
68760,	icate be executed physicien and s the burial-transit	edicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of):						
687		edica	•	d							
P.O. Box	iding Physicien: The law requires that the death certifin. In. After this certificate has been signed by the attending: After this certificate has been signed by the attending of funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Monti		ray Year
	w requires that s been signed b should be deta	þ	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause given	in Part I.				cause of death?
) Division of Vital Records,	Physicien: The law ruths certificate has be rail director, page 2 sh	Completed		1					24b. We pride	ath?	y findings available pletion of cause of
ž.	ysicie s certi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2 ER/Outpatie	Othor	26. Place of Death (ce ATMOther	(Specify)	CCENE
ion of	ath. rr, After this ne funeral di	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	Forma Date of Inju	ry 28b Time	of unk 28c. Injury a	at 28	d. Describe how			unk
Sivis	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Atter	Certification:	3 ☐ Suicide 6 🕰 Could not l 4 ☐ Homicide determined		ury - At home, farm, s c. (Specify)	street, factory, office		If. Location (Stre City or Town, Bro			· Ritchie MD
(P)	the Hospitei hin 24 hours the Funerel the Funerel npletely filled	Medicai	29a. Certifier 1 Certifying P	hysician: To the best miner: On the basis of and manner sta	examination and/or i	ath occurred at the time, investigation, in my opin	, date and place, an	d due to the cau	se(s) and mann	ner as state	ed.
	To th withir To th	Me	29b. Signature and title of certifier	10,111		29c. License r			I. Date signed (
ð	MAN		30. Name and a ress of person who	completed cause of					July 27,		5
	Sta	te	31. Date filed (Month, Day, Year)	32. Degistra	ar's Signature	nn Street,	Baltimore	e, Maryl	and 212	ZOT	
	Registr		AUG 0 2 2	005	N H A	parle					

			1 - For State Registrar	ate of Maryland / I	Department o		-	giene Reg. N 2005	25084
	Physici	an.	Decedent's Name (First, Middle, Last)				2. Date of De July		3. Time of Death
	/Medic		ANTHONY	BRUN					9:02 а м
	Examin	ier	4a. Facility Name (If not institution, give street Univ. Of Maryland			na, or Location of Deat 1MOTE		4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sex 159 16 0538	7. Age (In yrs. last bit		ays Hours Min.	Sept.	8, 1920 Pe	hplace (State or Foreign country) ennsylvania
	D		Usual Residence of Decedent						
	arylan show	_	10a. State 10b. County	10c. City, Tow	vn or Location timore				10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	the M	ecto	Maryland Anne Arund	er bar	10f. Zip Cod	de		10g. Citizen of What C	
	23a or	ral Dir	190 W. Meadow Roa	d		21225		U.S.	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-1 show important: If Item 27 is marked other than "natural", or Itema 23a or 28a-1 show appringly or other traumatic event, the Medical Examinal tenditied at once.	by Funeral Director	A 1 □ Never Married 2 1 Married 1	as Decedent Ever in U.S. med Forces? ™Yes 2 No Yes, Give WW II	13. Was Decedent If Yes, specify 1 Yes 2 🛭	of Hispanic Origin? (S Cuban, Mexican, Puer No Specify:	pecify Yes or No to Rican, etc.)	Specify: Wh	te, etc.
2-0	72 hc "natur	Completed	15. Decedent's Education (Specify only highest grade com	pleted) 16a	Decedent's Usual O	ccupation one during most of wo etired)	rking	16b. Kind of Business	/Industry
121	within ene. than	dmo	Elementary/Secondary (0-12) C	3HBGB (1-40F5+)	Supervicor	etirea)		Baltimore	Citv
	filed Hygie other ent, L		17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle	, Maiden Sumame)	
<u>'lan</u>	Aental Mental rked c	To Be	Pasquale	Bruno		Fra	nces Pad	lula	
Maryland	2 should and Men Is marke		19a. Informant's Name/Relationship (Type, F					er, City or Town, State,	
	and and marking markin		Marjorie Bruno / wi		90 W. Mead		Baltimo Date	re, Marylan	
Baltimore,	Pages 1 nent of H int: If Ite iry or ot		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	al from State cemete	of Disposition (Name of ery, crematory or other on Park Cem	netery 8/1/		Baltimore,	
Balti	permit. Departn Imports ony inju		21. Signature of Funeral Service Licensee					neral Servi	ce, P.A. yland 21225
			23a. Parki. Enter the disease, or complication shock, or heart failure. List only one ca	is that caused the death. Do					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	acute Myocar	dial Inf	arction			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence					,
н	Exammer	7	Sequentially list conditions, b.	Coronary Art Due to (or as a consequence		ase			months
	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Complication		rauma			
,00	the burial-transit	Exa	resulting in death) Last	Due to (or as a consequence			NO	J. Hard	
68760	ficate b physic s the b	edical	d				THE WOLL		
O. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	yes, outcome of pregnancy □Live birth 2 □ Fetal death □ Pregnant at time of death □ Unknown	h 3 Ectopic pregn 5 Other (specif		A TOST	23d. Date of de Month	olivery Day Year
Q.	res that signed by		Part II. Other significant conditions contribu	ing to death but not resulting	in the underlying caus	e giver Part I.	23e. Did 1	tobacco use contribute t	o the cause of death?
ords	w require been sig should b	ted t	Sepsis				10	Yes 2□No 3□P	robably 4 🔁 Unknown
Records,	alclan: The law r certificate has be irector, page 2 sh	Completed by					24a. Was auto perfo 1 Yes	san 24b. Were a prior to death?	utopsy findings available completion of cause of
of Vital	clan: ertifice sctor, p	BeC	25. Was case referred to medical examiner?				ath (Check only		
of \	Phyalclan: this certific ral director,	မ	examiner? XXYes 2□No Hospi	1 ☐ Inpatient				idence 6 Other (Spe	ecify)
n (ding After fune	lon	- I diding	(Month, Day Year)		Injury at Work? 1 ☐ Yes 2√ No		nt Fell	
Division	Attending r death.	flca	3 Suicide 6 Could not be	/ 20 / 05 7 : 3 e. Place of Injury : At home, f.	о Р		29f Location /	Street and Number or R	
Di	s after	Serti	4 Homicide	building, etc." (Specify) Home			rookly	yn, Md W.	. Meadow R
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Certification:	(Check only 2 Medical Exeminer:	: To the best of my knowledg on the basis of examination and and manner stated.	ge, death occurred at the nd/or investigation, in	he time, date and place my opinion, death occ	e, and due to the urred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within To the	Me	29b. Signature and title of certifier	Hay Long Dhy		cense number		29d. Date signed (Mon. Aug 1, 20	
)	15		Marcia & Cox	mo 1					
ĵĵ	1 1 1		30. Name and address of person who comple Marcia A. Cort, M	od cause of death (Item 23a)	ene Stree	et, Balti	more, N	Md 21201	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature					
	Regist		AUG 0 2 2005	Stown &	porte				
DΗ	IMH 17 Rev 1/2	:U01		7.0000	GINAL				

		1	For State Registrar	State of	Marylar		artment rtificate			and M		Reg. No.	2005	25085
	Physicia	an	1. Decedent's Name (First, Middle ETHEL M. BEST								2. Date of De Month 7-27	Day	Year	3. Time of Death 6:30 P M
	/Medic Examin		4a. Facility Name (If not institution MAGNOLIA MANOR	-	nber)		4b. City, T	IMOR	E MD			ba	ounty of Death	e
	Funeral Director		5. Social Security Number 219–18–0552	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. 89	last birthday) Yrs.	If Under 1 Months	Year Days	If Under	24 Hrs. Min.	8. Date of Bi (Month, D. 5-30-	rth av Year) -1916	9. Birth Cou	place (State or Foreign intry) VA
	Maryland -f show		Usual Residence of Decedent 10a. State 10b. County MD Balti	more		ty, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the la or 28e Lbe retil	Direc	10e. Street and Number 900 S. Rolling	Rd			10f. Zip (Code 1228				10g. Citize	n of What Cou	untry?
36	72 hours after death with the Maryland natural', or Items 23a or 28e-f show disal Examinat must be multified at	by Funeral Director	11. Marital Status 1 Never Married 2 Marr 3 Widowed 400 ivorced	12. Was Dece Armed Fo	ces? 2X No e X		Was Decede		spanic Ori n, Mexican Specify:	gin? (Spe n, Puerto I	cify Yes or N Rican, etc.)		. Race - Amer Black, White pecify:	
Maryland 21215-0036		Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	t's Education		(Give	dent's Usual kind of work DO NOT use	k done a	tu <i>ring m</i> os	t of workii	ng		of Business/line	ndustry
ind 2	be filed withIn tal Hygiene. d othar than event, the Me	Be	17. Father's Name (First, Middle,				Hom		18. Mothe		(First, Middle	e, Maiden Su		
Maryla	nd 2 should be fall and Mental I	<u>۲</u>	John Lloyd Ing 19a. Informant's Name/Relations Steven P. Davis	hip (Type, Print)	dson		-	(Street a	nd Numbe	er or Rura		ber, City or 1	Town, State, Z 2104:	_
Baltimore,	Pages 1 and nent of Heelth int: If itam 27 iry or other to	- Acres	20a. Method of Disposition 1 ★Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		State	Place of Dispo cemetery, cre Len, Hav	matory or oti	her place			Pate		ation - City or 1	
■ Baltin	permit. Pages Department of I Important: If its any injury or of		21. Sign and Funeral Service K. Gregory F 23a. Part Enter the disease or shock, a heart failure—List	Lic (See	MO1148) Î	Name and ink Fi 26 Cr	Addres uner ain	al Ho	Sme,	P.A.	ırnie,	MD 21	
8760,	death cartificate be executed Examine and correct as as the buriat-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, I as you are to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consector as	quence of):	eriosc	lero	tic (Cardí	lovascu	ılar D	iseasc	Onset and Death Uears
O. Box 6	at the death cartificaby the attending platached for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		irth 2 ☐ Fet ant at time of	al death 3 (□Ectopic pre					23	ld. Date of deli Month	very Day Year
rds, P.	ss the	by	Part II. Dther significent conditi	ons contributing to de	eath but not re	sulting in the u	underlying ca	ause give	en in Part I			tobacco use		the cause of death?
Il Records,	The ate h page	Completed									24a. Wa auto per 1 🗆 Yes	opsy formed?	prior to death?	topsy findings available completion of cause of 2 No
Vital	C8 C8	o Be	25. Was case referred to medical examiner?	Hospital:		TER/Outs stic	2	Oth			Check only		□Other (Spec	nife)
of	After After		1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident invest	28a. Date (Mon.		ER/Outpatie 28b. Time o Injury		8c. Injun Worl	/ at		28d. Describe			aiyj
Division	7 2 2 -	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 200. Place	of Injury - At I ng, etc. <i>(Sp</i> ec	nome, farm, si ify)	treet, factory	, office				(Street and own, State)	Number or Ru	ral Route Number,
	To the Hospitel or At within 24 hours after d To the Funerel Direct completely filled in by	edical (29a. Certifier 1 Certifyii (Check only one) 1 Medical	ng Physician: To the Exeminer: On the b and man	best of my kn asis of examin ner stated.	owledge, dea ation and/or i	th occurred anvestigation,	at the tin	ne, date ar pinion, dea	nd place, ath occurr	and due to the	e cause(s) a e, date and p	ind manner as place, and due	stated. to the cause(s)
)	To th withir To th comp	Me		-Gall	•				o number	96			signed (Montl	h, Day, Year)
	6		30. Name and address of person Laurence R. Ga			m 23a) (Type Maiden		e La	ne,	Balti	imore,	MD 2	1228	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year AUG 0 2		legistrar's Sigr									

DHMH 17 Rev 1/2001

ORIGINAL

	1 - For Stata Registrar			Cer	tificate of L	Death		Reg. No.	005	25086
an	Decedent's Name (First, Midd	le, Last)					2. Date of De Month	Dave	005 Yeer	3. Time of Death
al	WILLIAM L. BAR				# 05 T		JÜLY	-		6:40 P M
er	4a. Facility Name (If not institution 11405 ILLINOIS	_	imber)		SEVERN	Location of Death			County of Deat NE ARUI	
	5. Social Security Number	6. Sex 1 M 2 ☐ F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	v. Year)	9. Birt	thplace (State or Foreign
	213-36-4568 Usual Residence of Decedent		68				NOV. 1	1, 15	936 MAR	KILAND
	10a. State 10b. County	/	10c. Cit	y, Town or Loc	cation					10d. Inside City Limits
cto	VIRGINIA CARRO	LL	CA	NA 						1 ☐ Yes 2 🗓 No
Director	10e. Street and Number	A T T			10f. Zip Code				en of What Co	
Funeral	30 RUDISILL TR	-	cedent Ever in U	6 12 14	24317	innania Origina /Cr			D STAT	
Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Mar	Armed F	orces?		Vas Decedent of Hi Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.))-	Black, Whit	
ò	3 ☐ Widowed 4 💥 Divorced	If Yes G	ive	1	Yes 2X No	Specify:		5	Specify: WH	IITE
etec		nt's Education est grade completed)	(Give)	ent's Usual Occupa	during most of work	kina	16b. Kin	d of Business	/Industry
Completed	Elementary/Secondary (0-12)		(1-4or 5+)	life. D	OO NOT use retired DRIVER)	-	тр	ANSPOR'	TATION
	17. Father's Name (First, Middle,	Last)		INOCK	DILANK	18. Mother's Nam	ne (First, Middle			
o Re	HERBERT WILLIA	*	ARNES			MILDRED			•	
-	19a. Informant's Name/Relation			19b. Mailin	g Address (Street a	and Number or Ru	ral Route Numb	er, City or	Town, State, 2	Zip Code)
	WILLIAM L. BAR	NES, JR./	SON	11405	5 ILLINOI	S AVE.,	SEVERN,	MARY	LAND 2	1144
	20a. Method of Disposition 1 X Rurial 2 Cremation	3 Demoval from	1 ,	Place of Dispos cemetery, crem	sition (Name of natory or other plac	e) AUGU	Date ST 3	20c. Loc	ation - City or	Town, State
	'4 □ Opriation 5 □ Otro	Specify)	ME.	ADOWRII	OGE MEM.			ELKR	IDGE, 1	MARYLAND
	21. Signature of Teneral Service	Licensee		22. K I	Name and Addres	ss of Facility	NERAL HO	OME.	P.A.	SEW BAY Y
	10 01			142	21 CRAIN	HWY., S.	E., GLE	N BUK	NIE, M	
	23a. Part1. Enter the disease, of shock, or heart failure. Lis Immediate Cause (Final	t only one cause on	each line.	n. Do not ente	er the mode of dyln	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	disease or condition resulting in death)	a	Cur	reg .	con	er				2 year
		Due to	(or as a conseq	querice or):						9
ē	Sequentially list conditions, if any, leading to immediate	Due to	(or as a conseq	uence of):						
=	cause. Enter Underlying									
xamlr	if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	c	(or as a consec	mence of).			-			
æ	that initiated events		(or as a conseq	uence of):					5	
a	that initiated events	c	o (or as a conseq	uence of):						
æ	if FEMALE: 23b. Was decedent pregnant	d	utcame of pregna	ancy				23	3d. Date of del	livery
7	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	d	utcome of pregna birth 2 Feta	ancy	Ectopic pregnancy Other (specify)			23	3d. Date of del Month	livery Day Year
T T	If FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	d	utcome of pregni birth 2 Feta nant at time of d	ancy Il death 3 [] leath 5 []	Other (specify)		222 Did		Month	Day Year
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	d	utcome of pregni birth 2 Feta nant at time of d	ancy Il death 3 [] leath 5 []	Other (specify)	en in Part I.	-	obacco us	Month e contribute to	Day Year the cause of death?
by Physician/Medical	If FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	d	utcome of pregni birth 2 Feta nant at time of d	ancy Il death 3 [] leath 5 []	Other (specify)	en in Part I.	12	obacco us	Month e contribute to	Day Year to the cause of death?
by Physician/Medical	If FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	d	utcome of pregni birth 2 Feta nant at time of d	ancy Il death 3 [] leath 5 []	Other (specify)	en in Part I.	1 24a. Was	obacco us Yes 2 🗆	Month e contribute to	Day Year to the cause of death?
completed by Physician/Medical	Inst initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condit	d	utcome of pregni birth 2 Feta nant at time of d	ancy Il death 3 [] leath 5 []	Other (specify)		1 24a. Was auto perfo	obacco us Yes 2 an psy prmed? 2 X No	Month e contribute to	Day Year the cause of death? robably 4 Unknown
o Be Completed by Physician/Medical	If FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	d	utcome of pregni birth 2 Feta pnant at time of d nown	ancy It death 3 leath 5 ulting in the un	Other (specify)	26. Place of Dea	24a. Was auto perfo	obacco us Yes 2 an psy urmed? 2 No	Month e contribute to No 3 pr 24b. Were au prior to death? 1 Yes	Day Year the cause of death? robably 4 Unknown utopsy findings available completion of cause of
To Be Completed by Physician/Medical	Instituted events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d. 23c. If yes, or 1 Live 4 Preg 9 Unkilions contributing to 6	utcome of pregnibirth 2 Feta prant at time of conown death but not res	ancy It death 3 leath 5 ulting in the un	Other (specify) Inderlying cause give t 3 DOA Other	26. Place of Dea er: 4 ① Nursing H	1 24a. Was auto perfo	obacco us Yes 2 an psy primed? 2 No psy one) dence 6.	Month e contribute to No 3 pr 24b. Were a prior to death? 1 yes	Day Year the cause of death? robably 4 □Unknown utopsy findings available completion of cause of 2 □ No
To Be Completed by Physician/Medical	In a tinitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d. 23c. If yes, or 1 Live 4 Preg 9 Unkilions contributing to 6 lines at 1 28a. Date (Modigation	utcome of pregni birth 2 Feta pnant at time of d nown death but not res	ancy It death 3 leath 5 ulting in the un	Other (specify) Inderlying cause give t 3 □ DOA Other 28c. Injury Work	26. Place of Dea er: 4 ① Nursing H	1 24a. Was auto perfici 1 yes th (Check only come 5 Resi	obacco us Yes 2 an psy primed? 2 No psy one) dence 6.	Month e contribute to No 3 pr 24b. Were a prior to death? 1 yes	Day Year the cause of death? robably 4 Unknown utopsy findings available completion of cause of
To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions are referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendical Natural 5	d. 23c. If yes, or 1 Live 4 Preg 9 Unkers contributing to 6 ions con	utcome of pregnibith 2 Feta prant at time of conown death but not result of the conown	ancy It death 3	Other (specify) Inderlying cause give t 3 □ DOA Other 28c. Injury Work	26. Place of Dea ar: 4 Nursing H	24a. Was auto performent of the Check only of the Check on	obacco us Yes 2 an psy psy primad? 2 No pone) dence 6. how injury	Month e contribute to No 3 Pr 24b. Were au prior to i death? 1 Yes Cher (Spe occurred	Day Year the cause of death? robably 4 Unknown utopsy findings available completion of cause of
Certification: To Be Completed by Physician/Medical	In a tinitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d. 23c. If yes, or 1 Live 4 Preg 9 Unkersions contributing to 6 all Hospital: 1 28a. Date (Morigination not be mined 28e. Place build	utcome of pregnibith 2 Feta pnant at time of onown death but not res Inpatient 2 a of Injury nth, Day Year) se of Injury - At h ding, etc. (Specia	ancy It death 3	other (specify) Inderlying cause give t 3 DOA Other 28c, Injury Work 1 DOA eet, factory, office	26. Place of Dea er: 4 □ Nursing H / at /? Yes 2 □ No	24a. Was auto perfc 1 Ves th (Check only of ome 5 Resident 28d. Describe 28f. Location (City or To	obacco us Yes 2 an psy ormad? 2 No one) dence 6. how injury Street and wn, State)	Month e contribute to No 3 Pr 24b. Were a prior to death? 1 Yes Cother (Special Control Co	Day Year to the cause of death? robably 4 Unknown utopsy findings available completion of cause of a 2 No crify) SON S HO
Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condit. 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendi invest 2 Accident 3 Suicide 6 Could detern. 29a. Certifier 1 Certifyi	23c. If yes, or 1 Live 4 Preg 9 Unking India: 28a. Date (Moligation Inot be mined 28a. Plac built I Examiner: On the	utcome of pregnibith 2 Feta phant at time of chown death but not result of the phant of the phan	ancy It death 3 Itelath 5 Itelath 5 Itelating in the unit in	t 3 DOA t 3 DOA 28c. Injury Work M 1 DOA	26. Place of Dea er: 4 ☐ Nursing H / at √? Yes 2 ☐ No	24a. Was auto perfc 1 Ves th (Check only come 5 Resi 28d. Describe 28f. Location (City or To	obacco us Yes 2 an psy ymmed? 2 X No one) dence 6. how injury Street and wn, State)	Month e contribute to No 3 Pr 24b. Were au prior to death? 1 Yes Cher (Spe occurred	Day Year to the cause of death? robably 4 Unknown utopsy findings available completion of cause of 2 No cify) SON S HO
To Be Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d. 23c. If yes, or 1 Live 4 Preg 9 Unking ions contributing to 6 ion	utcome of pregnibith 2 Fets prant at time of chown death but not result of the present of the pr	ancy It death 3 Itelath 5 Itelath 5 Itelating in the unit in	t 3 DOA t 3 DOA 28c. Injury Work M 1 DOA	26. Place of Dea er: 4 □ Nursing H / at √? Yes 2 □ No ne, date and place, pinion, death occur	24a. Was auto perfc 1 Ves th (Check only come 5 Resi 28d. Describe 28f. Location (City or To	obacco us Yes 2 an an any symmed? 2 Z No ane) dence 6. how injury Street and wm. State) cause(s) a date and p	Month e contribute to No 3 Pr 24b. Were au prior to death? 1 Yes Cher (Spe occurred	Day Year to the cause of death? robably 4 Unknown utopsy findings available completion of cause of 2 No cify) SON SHO

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 0 2 2005

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

32. Resistrar's Signature

			1 - For State of Registrar		artment of Health and I		ne . No. 2005	25087
	Physici /Medic			1. BONAVENT	T	9	Day 2005	3. Time of Death 3:10 ATT. M
	Examin	er	4a. Facility Name (If not institution, give street and num KESWICK		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
	Funeral Director		5. Social Security Number 214-14-3771 6. Sex 1 M XX F	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y)	9. Birth Cor	nplace (State or Foreign INTY) IARYLAND
	Maryland a-f show	ctor	10a. State 10b. County N/A	10c. City, Town or Lo	BALTIMORE			10d. Inside City Limits 1 XX es 2 □ No
	with the 3a or 28a	I Director	10e. Street and Number 4401 ROLAND AVENUE		10f. Zip Code 21210	10g	. Citizen of What Col	
036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, Ite Marical Examinate and be muffied at	by Funeral		XI No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert □ Yes	pecify Yes or No- p Rican, etc.)	14. Race - Amer Black, White	ican Indian,
21215-0036	filed within 72 ho Hygiene. yther than "natur ant, Ine Mexical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YEARS College (1-	(Give	dent's Usual Occupation kind of work done during most of wor DO NOT use retired) HOUSEWIFE	king	b. Kind of Business/l	
Maryland	2 should be fill and Mental His marked oth aumatic even	To Be	17. Father's Name (First, Middle, Last) WILLIAM A. FISCHER		CAT		POLLARD	
	Health and tem 27 is mother traum		19a. Informant's Name/Relationship (Type, Print) FRANK C. BONAVENTURE, JR	(SON) 815	ng Address (Street and Number or Ru DROHOMER PLACE,,B	ALTIMORE,	MARYLAND,	21210
Baltimore,	Pages 1 ar		20a. Method of Disposition 1XXSurial 2 □ Cremation 3 □ Removal from S 4 □ Donation 5 □ Other (Specify)		matory or other place)		c. Location - City or 1 .KRIDGE, M	
Balti	permit. Pages. Department of the Important: If ite any injury or of once.		21. Signature of Funeral Service Licensee		2. Name and Address of Facility UCK TOWSON FUNERA	L HOME, INC	1050 YO TOWSON,	RK ROAD MD.21204
	Physician /Medical		23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ex Immediate Cause (Final disease or condition resulting in death)	ch line.	tor the mode of dying, such as cardiac gasture the art of Alexand for Alexander			Approximate Interval Between Onset and Death (LOV)
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	colorey a	rtery disease			Years
8760,	sate be executed oblysician and the burial-transit	edical Examiner	that initiated events C.	or as a consequence of):				
P.O. Box 68	The law requires thet the death centificate be executed tie has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physiclan/Med	in the past 12 months?	int at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delin	very Day Year
	quires thet n signed b uld be deta		Part II. Other significant conditions contributing to de Lavar alexander			23e. Did tobac	co use contribute to	the cause of death?
al Records,		Completed by	dacral deendixus 0s teanyelixis			24a. Was an autopsy performer	prior to o	opsy findings available ompletion of cause of
f Vital	ryeician: The is certificate hi director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Ir	patient 2 ER/Outpatie	0.1	th (Check only one) ome 5 🗆 Residenc	e 6 □Other (Spec	ify)
ion of	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifies completely filled in by the funeral director,		2 Accident investigation	f Injury b, Day Year) 28b. Time o Injury		28d. Describe how		
Division	To the Hospital or Attend within 24 hours after death to the Funeral Director: completely filled in by the	Certification;	3 Suicide 6 Could not be determined 28e. Place buildir	of Injury - At home, farm, st. g, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rui State)	al Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dii completely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the 2 Medical Exeminer: On the ba and mann	sis of examination and/or in	h occurred at the time, date and place vestigation, in my opinion, death occu	and due to the caus rred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the comp	M	29b. Signature and title of certifler Multiplelle Mas	nego on	29c. License number		Date signed (Month	
3	1		30. Name and address of person who completed cause NIBABEUC NACREGOR	of death (Item 23a) (Type, 700 W 40	Print) 46 STREET, BAL	TIMORE, T	702121	i
	Sta Registi		31. Date filed (Month, Day, Year) (32. Re AUG 0 2 2005	gistrar's Signature	Print) H STREET, BAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item: 19b State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month BROWN ULY **Physician** 2005 SRAE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTI RANDALLSTOWN WHC MOR If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 1M M 2□ F **Funeral** 081-16-1040 Director 08/25/1923 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State Pages 1 and 2 should be filed within 72 hours after death with five Marylar nent of Health and Mental Hygiene.
ant: if item 27 is marked other than "natural", or itams 23a or 28a-f show ury or other traumatic event, it a Madical Exerting must be inclined at 1 Yes 2 □ No BALTIMORE MD N/A Be Completed by Funeral Director 10g. Cilizen of What Country? 10f, Zip Code 10e. Street and Number 21215 6317 PARK HEIGHTS AVENUE #302 U.S.A. 12. Was Decedent Ever in U.S. Anyed Forces? 1 Pyes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) GUARDIAN PRESS OWNER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) **BROWN** SHERIN LENA CHARLES 2 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 788LINCOLN AVENUE - WINNETKA, IL 60093 ALAN BROWN / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Buriai 2 ☐ Cremation 3 ☐ Removal from State perrit. Page Depirtment of Important: if any injury or once. 08/01/2005 RANDALLSTOWN, MD BETH EL MEMORIAL ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitySOL LEVINSON & BROS., INC. 21. Signature of Feheral Service Licensee 8900 REISTERSTOWN ROAD - PIKE
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EREBROVASCULAR ACCIDEN Priysician DAYS /Medical Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year ō in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. | detached 9 Unknown 9 Unknown signed by 23e. Did lobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death bull not resulting in the underlying cause given in Part II. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2,200 hes 2 No 1 ☐ Yes 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be H W.H 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/OutpatienI Other: 4 Nursing Home 5 Residence 6 Other (Specify) Subacultur ္င 3 DOA this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of After Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Diractor: filled in by the 3 🗀 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, farm, slreet, factory, office building, etc. (Specify) determined 4 Momicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier alun death (Jem 23a) (Type, Print) of person who completed cause of 30. Name and address KANDALLSTOWN MARYLAN COURT 540 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 0 2 2005

DHMH 17 Rev 1/2001

ORIGINAL

		1	For State of Marylar State Registrar		artment of Hertificate of L			iene _{99. No} 20 (05 25089
			I. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	h Day	3. Time of Death
	Physicia	_	Francis Harry Custance				July	7	005 5:08 P. ^M
	/Medic Examin		a. Facility Name (If not institution, give street and number)		4b. City, Town, or			4c. County	_
ш			8720 Ridge Road Apt 318			tt City If Under 24 Hrs.	9. Data of Righ		Ward
	Funeral	1	1 KIM 2 □ E	. last birthday)	Months Days	Hours Min.	8. Date of Birth (Month, Day, March 12	Year)	9. Birthplace (State or Foreign Country) New York
	Director		065-01-4325 Usual Residence of Decedent	88 TIS.			March 12	2,1917	New TOTK
	land	-		ity, Town or Lo	ocation				10d. Inside City Limits
	Mary	ō	Maryland Howard I	Ellicot	t City				1 □ Yes 2 No
	h the	lrec	10e. Street and Number		10f. Zip Code		1	0g. Citizen of V	
	th wit	alD	8720 Ridge Road Apt 318		210			U.S.A	e - American Indian,
	hours after death with the Maryland turat; or Items 23a or 28a-f show a Exaniner must be nutitied a	Funeral Director	11. Marital Status 12. Was Decedent Ever in Armed Forces?	J.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecity Yes or No- Rican, etc.)		k, White, etc.
36	s afte	by Fi	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW		1 ☐ Yes 21X No	Specify:		Specify	White
8		ed t	15. Decedent's Education	16a Dece	dent's Usual Occup	ation	ing	16b. Kind of Bu	usiness/Industry
15	within 72 ene. than "na	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life.	kind of work done of DO NOT use retired	during most or work ()	my		
212	d with giene ar tha	Completed	12	Insur	ance Adju			Insuran	
B	be filed ital Hygie d other	Be (17. Father's Name (First, Middle, Last)			18. Mother's Nam		Maiden Suman	16)
yla	should be and Mental stranked o	ပ္	John Custance	401-44-15	ing Address (Street	Sophie Ho		r City or Town	State, Zin Code)
Maryland 21215-0036	2 should and N la main		19a. Informant's Name/Relationship (Type, Print)						y, MD 21043
	s 1 and 2 should of Health and Men item 27 is marke other traumatic		Dorothy Custance (Wife) 20a. Method of Disposition 20b	Place of Disp	osition (Name of		Date		City or Town, State
סר	Pages nent of h ant: If its ury or o				matory or other place. National		2005	Baltimo	re, Maryland
Baltimore,	permit. Pages Department of Important: If i any injury or once.		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee)	11/2	2 Name and Addre	ss of Facility			
Ba	permit. Departr Imports any inji		Danier Dalson	tee W	itzke Fun	eral Home	e of Cat Catonsv	onsvill ville. M	e, Inc. Maryland 21228
PARTY IN	Pnysician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consider of the conditions) Sequentially list conditions,	eath. Do not en	nter the mode of dyir	ng, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death MCNTH
68760,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons of the constant of the cause) Due to (or as a cons of the cause) Due to (or as a cons of the cause)						
.O. Box 6	the death certifi y the attending iched for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of preduction in the past 12 months? 4 □ Pregnant at time of 9 □ Unknown	etal death 3	☐Ectopic pregnanc☐ Other (specify) _	у		Me	ate of delivery onth Day Year
Δ.	uires that signed b ld be deta		Part II. Other significant conditions contributing to death but not 1 ABETES MELLITUS, Cobob				23a. Did to		tribute to the cause of death? 3 Probably 4 Unknown
of Vital Records,	2 3 8	Completed by	ISCHEMIC CARSIDMYO PATHY				24a. Was autor perfo 1 - Yes		Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
tal	ician: Th certificate rector, pag	a	25. Was case referred to medical			26. Place of Dea	ath (Check only o	one)	
>	Phyaician: r this certific ral director.	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	2 ☐ ER/Outpati	ent 3 DOA	her: 4 Nursing F		dence 6 □Ot	
o uo	fe fe		27. Manner of Death 1 XNatural 5 Pending 2 Accident Accident Accident Support	28b. Time r) Injury	/ VVc	iry at ork?] Yes 2 □ No	28d. Describe I		
Division	Hoapital or Attending 24 hours after death. Funeral Director: After tely filled in by the tune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury : A building, etc. (Sp	t home, farm, s	street, factory, office		28f. Location (: City or Tox	Street and Num wn, State)	ber or Rural Route Number,
	To the Hoapital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the t	ledical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of exam and manner stated.	knowledge, de nination and/or	ath occurred at the linvestigation, in my	ime, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and m date and place	nanner as stated. , and due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier		-	ise number			ed (Month, Day, Year)
	- 5 - 0		Afthe uns		D3	8296		AUG	1,2005
	3		30. Name and address of person who completed cause of death of the state of the sta	PG LAN	SK Noow	N RD; Su	ाह है।		DGE, MD 21075
	S Regis	tate trar	31. Date filed (Month, Day, Year) 32. Registrar's S	4004	W				

			For State Registrer	11000			nd / Dep	artment of rtificate of	Health a		lental Hyg	iene	005	25090
	Physici	an	1. Decedent's Nam								2. Date of Deat Month	h Day	Year	3. Time of Death
	/Medic		Ethel		Chillo						07	_20_	05	2:59 P M
3	Examin	er	4a. Facility Name (imber)		4b. City, Town,					unty of Death ntgome	
	Eupovol		5. Social Security N	ross Hos	pital	7. Age (in yr:	s. last birthday	If Under 1 Yea		24 Hrs.	8. Date of Birth	1	9. Birth	place (State or Foreign
П	Funeral Director		087-18-11		1 ☐ M 2 🖾 F	87	Yrs.	Months Days	s Hours	Min.	8. Date of Birth (Month, Day, 12 25	$\overset{Y_{\Theta ar})}{17}$	Cou	ith Carolina
	pu »		Usual Residence o	f Decedent 10b. County		100.0	City, Town or L	contine						10d. Inside City Limits
	faryla shov	70	MD	Montgom	erv		Takoma							15€ Yes 2 No
	28e-f	Director	10e, Street and Nu					10f. Zip Code			1	Oa. Citizen	of What Cou	intry?
	3a or	٥		rroll Av	o #503			20912					ISA	,
	death ms 2	Funeral	11. Marital Status	LIOIL AV	12. Was Dec	edent Ever in	U.S. 13.	Was Decedent of ff Yes, specify Cu		gin? (Spe	ecify Yes or No-	14.	Race - Amer	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23a or 28e-1 show eny injury or other treumetic event. It a Modical Examiliar is used by multiped at once.	by Fur	1 ☐ Never Man	ied 2☐ Married	Armed F 1 Yes If Yes, G Year or I	2 XNo		1 ☐ Yes 2 ☐XN		, Риепо	Hican, etc.)		Bfack, White ec <i>ify:</i> B1 <i>a</i>	_
21215-0036	72 ho	Completed by	(500)	15. Decedent's			16a. Dec	edent's Usual Occ	upation	of work	ina	16b. Kind o	of Business/Ir	ndustry
2	ithin 7	nple	Elementary/Seco	ondary (0-12)		(1-4or 5+)		kind of work don DO NOT use retir		OF WORK	ng			
7	ygien ygien her th	Con	4t1				Stan	np Cutter	1					ngraving
and	be fill hall H ad ott	Be	17. Father's Name		St)				18. Mothe	rs Name	e (First, Middle, M	Maiden Sur	name)	
Maryland	hould d Mex mark matic	우	Shed Ja 19a. Informant's N		(Type Print)		19h Maii	ing Address (Stree		~	Mons	City or To	um State 7i	n Code)
<u>B</u>	nd 2 s lith an 27 is i		Dolores			or								
ē,	s 1 ar f Hea item		20a. Method of Dis	position	-	20b.	Place of Disp	Carroll osition (Name of ematory or other p	arel	202	Date :	20c. Locati	on - City or T	own, State
Ë	Page ient o nt: If ry or						etropol			7-29	-05	Alexa	ndria,	VA.
Baltimore,	permit. Departm Importe eny inju		21. Signature of Fu	uneraf Service Lic	ensee			2. Name and Add			shall's	Fune	ral Ho	me
<u> </u>	89 = 9				aisha	ll		217 9th.					D.C. 2	0011
			23a. Part1 Enter t shock, or hea	the disease, or co art failure. List or	mplications that by one cause on	caused the de each line.	ath. Do not er	iter the mode of dy	ing, such as	cardiac o	or respiratory arre	est,		Approximate Interval Between
	Pnysician		Immediate Cause disease or condition resulting in death)	(Finaf on	_ a Ca	rdiac A	Arrthyn	ia						Onset and Death
	/Medical Examiner		resulting in death)	1		(or as a conse		a 1.						
		Į.	Saqueritially list out	onditions,		(or as a conse		Cardiov	ascula	r Di	sease			
	uted d ansit	Examiner	if any, leading to it cause. Enter Under Cause (Disease or	ertying injury										
o.	ate be executed nysician and he buriat-transit	Exa	that initiated event resulting in death)	Last	C. Due to	(or as a conse	equence of):							
,097	ite be iysicia ne bur	Ical			d									
89	The law requires that the death certifica Ite has been signed by the attending ph bage 2 should be detached for use as th	by Physician/Med	IF FEMALE:											
Box	ath ce	lan/	23b. Was deceder in the past 12		1□Live	itcome of preg birth 2 ☐ Fe	etal death 3	□Ectopic pregnan	су			23d.	Date of deliv Month	rery Day Year
o.	he de	yslc	1 ☐ Yes 2 9 ☐ Unknowr		4∐Preg 9∏Unkr	nant at time of nown	rdeath 5	Other (specify)						
<u>a</u>	that the ded by detact	/ Ph	Part II. Other signi	ficant condition	s contributing to	death but not re	esulting in the	underlying cause g	oven in Part I.		23e. Did tob	acco use o	contribute to t	the cause of death?
ds,	uires 1 sign Ild be		Diab	etes Mel	litus						1 □ Ye	s 2 N	o 3 🗆 Pro	bably 4 🖺 Unknown
0 0 0	w require been sign	lete									24a. Was a		4b. Were auto	opsy findings available
Re	The tav te has age 2	Completed									autops perform 1 🔼 Yes 2	ned?	prior to co death? 1 🛣 Yes	ompletion of cause of
Vital Record	ien: '	0	25. Was case refe	rred to medical					26. Place	of Death	(Check only on		T LONG T GOS	20110
	Physicien: this certific ral director.	To B	examiner? 1 Tes 2	№ 0			☐ ER/Outpatie	nt 3□ DOA	ther: 4 🗆 Nui	rsing Ho	me 5 🗆 Reside	nce 6 🗆	Other (Speci	fy)
ion of	Attending Pt ir death. ector: After th by the funeral	tlon:	27. Manner of Dea 1 ☑ Natural 2 ☐ Accident	th 5 Pending investigal		of Injury oth, Day Year)	28b. Time Injury	W	uryat ork? ⊒Yes 2 □1		28d. Describe ho	w in j ury oc	curred	
Division	or Atter	ertification:	3 Suicide 4 Homicide	6 Could no determine	ad 286. Plac	e of Injury - At ling, etc. (Spec	home, farm, s	treet, factory, office	9		28f. Location (St. City or Town		umber or Rur	al Route Number,
_	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical Ce	29a. Certifier (Check only one)	1 Certifying 2 Medical Ex	eminer: On the l	e best of my ke casis of examin	nowledge, dea	th occurred at the	time, date and	d place, a	and due to the ca	use(s) and ate and pla	manner as s	stated. o the cause(s)
	To the within 2 To the complet	Med	29b. Signature apt	title of certifier	and mai	iller stateu.		29c. Lice	nse number		29	9d. Date si	gned (Month,	Day, Year)
ì	F * F 8	/	X.	42.				D28	8656			Ju1v	25, 2	2005
	H		30. ame and add	ress of person when and Page	no completed cau	ise of death (It	em 23a) (Type nd Aven	Print) ue Silve	r Spri	ng.	MD. 2091		-, -	
	Sta	to.	31. Date filed (Mor	-		Registrar's Sig				-0,		_		
	Regist	ar		G 0 2 200			Agas	Sie)						
DH	IMH 17 Rev 1/2	001				A.G. 500	ORIGIN							

			For State Registrar		State of Ma	ryland /	•	rtment of H		and Me	-	giene	40115	25091
				e (First, Middle, Las	1)					2.	Date of Dea			3. Time of Death
	Physici		T	homas S.	Connell, J	r.				T	Month (Day	2005 Year	1445 M
}	/Medio Examir		4a. Facility Name (II	not institution, give	street and number)			4b. City, Town, or			7	4c.,	County of Death	
			11802	Shadysta	ne Teri	race_	-	mital	elvi	lle		P	rince 6	corges
	Funeral		5. Social Security N		7. Ag <i>e</i> XIM 2□F	(In yrs. last t		If Under 1 Year Months Days	If Under a	Min. 8.	Date of Birtl (Month, Day	/, Year)	Cou	place (State or Foreign intry)
	Director		222-18-0 Usual Residence of	0205	7	3	Yrs.				04 08	193	32 Dov	er, DE.
	land		10a. State	10b. County		10c. City, To	wn or Loc	ation						10d. Inside City Limits
	Mary Fish	ţ	MD	Prince G	eorges	Mitc	he11	ville						1 K Yes 2 No
	r 28e	Director	10e. Street and Nur	mber				10f. Zip Code				10g. Citi	zen of What Cou	intry?
	23e o		11802 S	hadystone	Terrace			20721					USA	
	ems er m	Funerai	11. Marital Status		12. Was Decedent E Armed Forces?		13. V	Vas Decedent of H Yes, specify Cuba	lispanic Orig	gin? (Specif	y Yes or No-		14. Race - Amer Black, White	
36	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural" or items 23e or 28e-f show event, i're Medical Ericrii er final be notified all	by Fu	1 Never Marri 3 Widowed	ed 2 Married	1 SYes 2 □ No If Yes, Give	0	1	☐ Yes 2 No	Specify:				Specify: Bla	ale
8	hour tural	ed b	3 - Widowed	15. Decedent's Ed	Year or Dates:	16	a. Deced	ent's Usual Occup	ation		1	16b Ki	ind of Business/li	
15	nin 72 n "na Nealls	Completed	(Spec	ify only highest grad			(Give I	kind of work done of NOT use retired	during most	t of working				,
212	d with giene	E O	Elementary/Seco	ildaly (0-12)	4 yrs.		PC	stal Wor	ker			U.	S. Post	Office
ם	al Hy l othe vent,	Be	17. Father's Name	(First, Middle, Last)	•						irst, Middle,		Sumame)	
<u>la</u>	Menta	5	Thomas	S. Connel	.1, Sr.				MAr	ie Wi	1kerso	n		
Maryland 21215-0036	s 1 and 2 should be filed within 'f Health and Mental Hygiene. item 27 is marked other then "item other traumatic event, I' a Me.	6		ame/Relationship (7	уре, Print)			g Address (Street						ip Code) 1 d. 20744
e,	t and tealth em 27 ther t	3	Sharon 20a. Method of Disp					MICCUTEL 1	reru I	Date	1		ocation - City or T	
Baltimore,	ages nt of h :: If ite	١,	1 □ yourial 2 i	Cremation 3	Removal from State	cemei	tery, crem	atory or other plac		8-02-			ltenham,	
를	iit. Partme artme orteni injury			5 Other (Specify neral Service Licen:		Mary		Veterans Name and Addre	1.		-			
Ba	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tra ance.		100	Maria	bull			17 9th.		LIMI			neral Ho	
			23a. Part J. Enter the	he disease, or comp	lications that caused one cause on each line	the death. Do							, 2.0. 2	Approximate Interval Between
	Physician		Immediate Cause disease or condition	(Final	ATT	les.	tre	Cardio	VASC	ular	Hea	I	Diseas	Onset and Death
	/Medical		resulting in death)	(Due to (or as a	consequenc								
	Examiner		Sequentially list co	nditions,	6									
	ed sit	Examine	if any, leading to in cause. Enter Unde Cause (Disease or	nmediate orlying injury	Due to (or as a	consequenc	e ot):							
	the death certificate be executed y the attending physician and tched for use as the burial-transit	xan	that initiated events resulting in death) I	6	c. Due to (or as a	consequenc	e of):							
8760,	e be e siciar e buri	dicai E			d									
9	tificat ng phy as th	ledi												
Вох	eath certific attending p	an/N	IF FEMALE: 23b. Was deceden		23c. If yes, outcome of 1 Live birth 2		th 3	Ectopic pregnancy	/			1	23d. Date of deliv	
	e dea the at ned fo	Physician/Me	in the past 12 1 Yes 2 [9 Unknown	□No	4☐ Pregnant at t 9☐ Unknown	ime of death	5 🗆	Other (specify)					MOITH	Day Year
P.0	that the de led by the a detached				ontributing to death bu	t not resulting	in the un	derlying cause giv	en in Part I		23e. Did to	obacco u	use contribute to	the cause of death?
ds,	gn g	d by	Tartin Guidi digiti		on in Sun Sun Sun Su	r riot roodning	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	identyling odddo gif	on mir circi			/es 2		
Vital Records,	w requir been si should	Completed									24a. Was	20	24h Wara aut	opsy findings available
Rec	The lav ate has page 2	ш									autop perfo	rmed?	prior to co	ompletion of cause of
G		ပိ	25. Was case refer	red to medical	···				as Place	of Death (1 ☐ Yes Check only o	2 No	1 🗆 Yes	2 No
	Physicien: r this certific ral director,	0	examiner?		Hospital: 1 ☐ Inpatier	nt 2 🗆 ER/0	Outpatien	t 3□ DOA Oth	oc				6 □Other (Spec	ifv)
J Of		n:	27. Man of Deat		28a. Date of Injun (Month, Day	Year) 28b	. Time of	28c. Injur Wor	y at		d. Døscribe h			
Sio	Attending r death. ector: After by the fune	atic	1 Natural 2 Accident	5 ☐ Pending investigation			,,		Yes 2	No				
Division	after de Directe	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Inju building, etc	ry - At home, (Specify)	farm, stre	eet, factory, office		281	Location (S City or Tow			ral Route Number,
	Hospital or 4 hours afte Funeral Dir tely filled in I		OO- O-Wes	1□ Cartifying Bh	initian Table has	f and be added				d =la=a aa.	d el			
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one)		ysician: To the best o liner: On the basis of and manner stat	examination :								
	To the within 2 To the complet	₩.	29b. Signature and	I title of certifier				29c. Licens	e number		:	29d. Dai	te signed (Month	, Day, Year)
	1	/	fa	Vadu .	49 vote	アクシ		150	253	927		Ju	ly 16	2005
1	5//		30. Name and addr	ress of person who	completed cause of de	ath (Item 23a	a) (Type,	Print)		- 1	0	_	1	- 1
6	1-1		SALVAdo	x Sy/w	Av, 300	-0	pite	al Dri	ve	Che	vely,	14	way /181	Nd
	Sta Regist	ate rar	31. Date filed (Mor	up, pay, Year)		r's Signature	-	2274			//		/	
DH	MH 17 Rev 1/2			0 % 200	J. S. College	- Si	100	The state of the s						
						OR	IGINA	L						

			1- State of Maryland State of Maryland			of Health ar of Death		giene	5 25000
	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last) Howard T Carola 4a. Facility Name (If not institution, give street and number)		-	wn, or Location of I	2. Date of Dea Month Tuly		5 0040 M
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 217-54-6315 56	Molica. st birthday) Yrs.	Conter If Under 1 Y	rear If Under 24	Hrs. 8. Date of Birth Min. (Month, Day), Year) 9. B	irthplace (State or Foreign Country)
	e Maryland	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Maryland Howard	Town or Lo	cation	Ellicott City	July 11,	1949	Maryland 10d. Inside City Limits 1 □ Yes 2 No
	eath with th	Funeral Director	10e. Street and Number 10271 Globe Dr. 11. Marital Status 12. Was Decedent Ever in U.S.	12.1	10f. Zip Co	2104	2		S.A.
9000	within 72 hours after death with the Maryland ene. than "netural", or Items 23e or 28e-f show he Medical Eva rither mat be metified at	d by Fun	1 Never Married 2 Married 1 Never Married 2 Married 2 No If Yes, Give Year or Dates:	1	1□ Yes 21X	No Specity:	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Am Black, Wh Specify:	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryla tof Health and Mental Hyglene. If item 27 is marked other than "netural", or Items 23e or 28e-4 show or other traumatic event, Tre Medical Exprinter marker in tilled at	Completed by	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4+	(Give	dent's Usual O kind of work d DO NOT use re	one durina most of	f working	16b. Kind of Busines	s/Industry Law
Maryland	2 should be filed with and Mental Hygiene. is marked other than aumatic event, ITEM	To Be	17. Father's Name (First, Middle, Last) Howard T. Carolan 19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (St		Name (First, Middle, Mary I or Rural Route Number	Elizabeth Abell	Zin Code)
			Mrs. Karen Carolan Wife 20a. Method of Disposition 1 □ Burial 2 ★ Cremation 3 □ Remova From State 20b. Placent	1C ce of Dispos		e Dr. Ellicott	City, Maryland		
Baltimore,	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee All Co Museum Survey May 21. Signature of Funeral Service Licensee May 21. Signature of Funeral Service Licensee May 21. Signature of Funeral Service Licensee	unty Cre	. Name and A	Services, Inc. ddress of Facility k Funeral Ho	ome, P.A.		e, Maryland
	Physician /Medical Examiner		23a. Fart1. Enter the disease, or complications that caused the death. Implications that caused the death. Implication to the art failure. List only one cause on each line. Implication cause (Final disease or condition resulting in death) a	1 1/	er the mode of	4	ident	est, WD 21043	Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to of as a consequence. C. Due to (or as a consequence)	nce of):	Matio	n			
.O. Box 68	The law requires that the death certifica tie has been signed by the attending ph age 2 should be detached for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Festal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	eath 3 □	Ectopic pregna Other (specify			23d. Date of de Month	livery Day Year
ords, P	w requires that been signed I should be det	by	Part II. Other significant conditions contributing to death but not resulting	ng in the und	derlying cause	given in Part I.		acco use contribute to	o the cause of death? robably 4 Unknown
		e Completed	25. Was case referred to medical			00 81		prior to death? No 1 ☐ Yes	utopsy findings available completion of cause of
of	ding Physic n. After this ce funeral direc	Certification: To B	examiner? 1 Yes 2 No 1 Inpatient 2 ER 27. Manner of Death 1 Natural 5 Pending 2 Accident Accident 28a. Date of Injury (Month, Day Year) 28a. Date of Injury (Month, Day Year)	VOutpatient Bb. Time of Injury	28c. li	Other	Death (Check only one g Home 5 Reside 28d. Describe ho	nce 6 Other (Spe	city)
Divis	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowle				City or Town	,	
	To the Hos within 24 h To the Fur completely	Medical	(Check only 2 Medical Examiner: On the basis of examination one)	and/or inve	estigation, in m	ny opinion, death o	ccurred at the time, da	te and place, and due	to the cause(s)
1	5		30. Name and address of person who completed cause of death (Item 23	3a) (Type, P	AUY Trint)	176935	F15270	July 27	2 2005
À	Sta Registr		30. Name and address of person who completed cause of death (Item 23 Sean M. Fox, MD 13 S. 31. Date filed (Month, Day, Year) AUG 0 2 2005	Jreth.	porte	T Owly	s mills m	U, Z1117	

			For State	State of Maryland		artment of h		i Mental Hy	201	ስር	25002
			Registrar 1. Decedent's Name (First, Middle, Last)			inoaic or	Dealii	2. Date of De	Reg. Ne. U	JJ	3. Time of Death
	Physici		William Patrick Co	leman. Sr.				Jun -	28 Z00	Year	8:0019 M
	/Medic Examir		4a. Facility Name (If not institution, give s		(en,	4b. City, Town, o	or Location of De		4c. County	of Death	Brunds
	Funeral Director		214-01-2655		st birthday) 94 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		rth ay, Year) 1911	9. Birthp Cou	place (State or Foreign ntry)
	fand ow		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation					10d. Inside City Limits
	Mary I-f sh	to	MD Anne Arun	del Lintl	nicum					i	1 ☐ Yes 2 No
	th the	lrec	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Cou	ntry?
	23a c	rai	508 Dogwood Road			21090		}	U.S.A.		
920	be filed within 72 hours after death with the Maryland tal Hygiene. do other than "neturel", or items 23s or 28s-f show event, the Medical Examirer must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of I f Yes, specify Cub I ☐ Yes 2∏ No	an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	Blac	e - Americk, White,	
2-0	72 ho	eted	15. Decedent's Edu (Specify only highest grade		16a. Deced	lent's Usual Occup kind of work done	pation	endring.	16b. Kind of Bu	usiness/In	dustry
21215-0036	vithin ne. han "u	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	00 NOT use retire	d)	roiking			
	filed with Hygiene. other than		17. Father's Name (First, Middle, Last)		OIIIC	e Manage		ame (First, Middle	Accoun		
Maryland	should be filed withir nd Mental Hygiene. marked other than matic event, the M	To Be	Patrick James Cole	man			Helen 1		, waldon obman	16)	
ary	s 1 and 2 should b f Health and Menti item 27 is marked other treumatic e	-	19a. Informant's Name/Relationship (Ty)	oe, Print) Son	19b. Mailin	g Address (Street		Rural Route Numb	er, City or Town,	State, Zip	Code)
	ss 1 and 2 of Health a item 27 is		Mr. William Patric	k Coleman, Jr.	. 508	Dogwood	Road,	Linthicum	n, MD 2	1090	
Baltimore,	of He of He If item or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	COL	nce of Dispo metery, cren	sition (Name of natory or other pla	сө)	Date	20c. Location -	City or To	own, State
Ë	Pag tment tent: jury c		`4 Donation 5 ☐ Other (Specify)	New	Cathe	dral Cem	etery	08-02-200	5 Balt:	imore	e, MD
Bai	permit. Pages 1 Department of H6 importent: If iten any injury or oth once.		21. Signature of Funeral Service License					ingleton			
			23a. Part1. Enter the disease, or compli					Glen Bur		210	Approximate
	Dhusisian		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	1	oke	19, 50011 45 5410	ao or rospiratory a			Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseque	> Y	OPC					
	Examiner		Sequentially list conditions								
	פ ב	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):						
	cate be executed physician and the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	. Dua to force a constant							
8760,	be ex ician a burial	ai E	and the second s	Due to (or as a conseque	ence or):						
387	icate physi s the I	dicai	d								
.O. Box (The law requires that the death certifii tle has been signed by the attending to page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \[Yes 2 \] No 9 \[Unknown \]	3c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown	death 3□	Ectopic pregnancy Other (specify)	′		23d. Dat	e of delive	ery Day Year
Vital Records, P.	uires that i signed by	by	Part II. Other significant conditions con		ting in the un	derlying cause giv	en in Part I.	23e. Did t	/	ribute to th	ne cause of death?
00	s been si should	ompleted						24a. Was	an 24b. V	Vere auto	psy findings available
Re	The lav	mo							prmed?	prior to con death?	mpletion of cause of
ital		e C	25. Was case referred to medical				26. Place of D	1 ☐ Yes eath (Check only o		LITES	21. No
of V	nysic lis ce direc	To B	examiner? 1 Tes 2 No	ospital: 15 Inpatient 2 E	R/Outpatien	3 DOA Oth	er: 4 🗆 Nursing	Home 5 ☐ Resi	dence 6 Othe	er (Specif	y)
Division o	anding lath. or: After he funer		27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injur Wor M 1 [yat k? Yes 2 ☐ No	28d. Describe	how injury occurr	ed	
Divis	itei or Attenders after deatlei Director:	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (City or To	Street and Number wn, State)	er or Rura	l Route Number,
	To the Hospitei or Attu within 24 hours after de To the Funerei Direct completely filled in by ti	edicai	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	icien: To the best of my knowler: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the tir estigation, in my o	ne, date and pla pinion, death oc	ce, and due to the curred at the time,	cause(s) and ma date and place, a	nner as st and due to	ated. the cause(s)
	To with Com	Σ	29b. Signature and title of certifier	ma		29c. Licens	e number		29d. Date signed	(Month,	Day, Year)
•	10			1 119		DH	2000		1/2	817	2005
	V		30. Name and address of person who co	TEY, 301	+	Print) -	1 12	1 6	Im [Sw,	Chy bin
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 2 2005	2. Registrar's Signatu	re Lace			1			

			For State Registrar	State of Mary		artment of H		, 4	iene	25001
ì	Physicia		1. Decedent's Name (First, Middle, Last		comb			2. Date of Deat Month		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	0419	4c. County of Deat) 3
8-5a		Ç.	Mariner Health			le Cat	onsville		Baltim	
П	Funeral Director		5. Social Security Number 6. S 295–12–3833	XM 2□ F 7. Age (/// 82	yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Mar. 26.		nplace (State or Foreign untry) nsvlvania
	and w		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ecation				10d. Inside City Limits
	Maryla f shor	tor	Md. n/a		,	imore				1 XYes 2 No
	th the or 28a e notifi	irec	10e. Street and Number		Dar	10f. Zip Code		1	0g. Citizen of What Co	untry?
	ath will	rai	2438 Christain St			21223			USA	
396	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It has 23s or 28s-f show itam 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Madical Exeminal must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar I ☐ Yes 2💆 No	spanic Origin? (Spanic Origin? (Spanic Origin)	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
2-0	72 ho	eted	15. Decedent's Ed (Specify only highest gra			dent's Usual Occupa kind of work done d		ina	16b. Kind of Business/l	
21215-0036	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)			Contractor	
Jd 2	e filed within al Hygiene. I other than ' vent, I're Ma	Be Co	12 17. Father's Name (First, Middle, Last)	0	Electr	onic Tech	nician 18. Mother's Name			
ylar	2 should be and Mental Is marked o aumatic eve	To B	Harry B. Claycom	b			Ardel]	la Weyan	t	
Maryland	12 sho h and 7 Is m traum		19a. Informant's Name/Relationship (, City or Town, State, Z	
re, l	Health tam 27 other tr		Rhoda B. Claycomb 20a. Method of Disposition		Ob. Place of Dispo	sition (Name of			re, Marylar 20c. Location - City or	
Baltimore,	80 = 5		Seurial Cremation 3 ☐ Cher (Specification) 5 ☐ Other (Specification)) L		natory or other place rk Cemete		/2005	Baltimore,	Maryland
Bai	permit. Pa Departmer Important: any injury once.		21. Ignalure of Funeral Service Licer	male		2. Name and Addres	110	abbard F	uneral Home	e, Inc.
H.	ę.		23a. Part1. Enter the disease, or com shock, or Heart failure. List only	plications that caused the					more, Mary	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	A 1.1	osclero	Jic CH	a die un	r culas	Disease	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co						
	*	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a co	nsequence of):				-	
k	acuted ind transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	с.						
8760,	death certificate be executed e attending physician and id for use as the bunal-transit		rosuling in usually East	Due to (or as a co	nsequence of):					
9	entificating phy	Medi	IF FEMALE:							
Вох	death certifica attending ph d for use as th	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pi 1 Live birth 2 4 Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
P.O.	t the by th ache	hys	9 🗌 Unknown	9□ Unknown						
	signed signed d be del	by	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the u	nderlying cause give	n in Part I.		oacco use contribute to es 2 ☑ No 3 ☐ Pro	
Vital Records,	law requires as been sign 2 should be	ompieted						24a. Was a		topsy findings available
Re	Ф <u>г</u> Ф	omo						autops: perform	y prior to c	ompletion of cause of
/ita	Physician: Th this certificate ral director, paç	BeC	25. Was case referre medical examiner?				26. Place of eath		-	
of	Phys this al dii	- To	1 ☐ Yes 2 ☑ No 27. Mann f Death	Hospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatien		4 Writing Ho		ence 6 Other (Spec	ify)
	Attending Ir death. ector: After by the funer	ation	1 atural 5 Pending 2 Accident investigation	(Month, Day Ye	ar) Injury	Work	? ′es 2 □ No	203. 2030.00 110	on injury occurred	
Division	in the	Certification;	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, str pecify)	eet, factory, office		28f. Location (Sti City or Town	reet and Number or Ru n, State)	ral Route Number,
	e Hospital 24 hours a Funeral l	dical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of miner: On the basis of exa	y knowledge, deatl mination and/or in	n occurred at the tim vestigation, in my op	e, date and place, inion, death occurr	and due to the ca ed at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	5/5/		29c. License	number	25	9d. Date signed (Month	i, Day, Year)
			19000	5//		DIS	872	_	July 29,	2005
	10+1		30. Name and address of person who Dr. Howard Rob 25			· ·	\$ 120°	21040	5 85	
	Sta	te.	Dr. Howard Bob 25 31. Date filed (Month, Day, Year)	Main Street	Reiste Signature	rstown, M	aryland	21040	0.000	
	Registr	ar	AUG 0 2	32. Registrar's	. K	had .	-0-			
	MH 17 Rev 1/2			# 100 FEE 18 FEE						

CPM05-05089 Unpend item#23a,27,28a-f,perME,6848,10-21-05 TT

State of Maryland / Department of Health and Mental Hygiene

Amend item#28a-b,i,perME,6850,12-30-05 TT Gene Dredden Department of Health and Mental Hygiene DerME, 6850 12-30 Mental Hygiene Certificate of Death 1 - For State Registrer Reg. No 2 0 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dredden **Physician** Gene July 2ďő5 28 10:09 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA 501 East Preston Street Apartment 724 Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8-21-73 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🗆 🗓 XI 2 🗆 F Months Days Hours 31 216-86-6672 Md. Director Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "netural", or items 23s or 28s-f ehow Md. Baltimore 1 Wes 2 □ No NA Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 East Preston Street Apt. 724 21202 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Plumbing Varies 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ford Diane James Lester Dredden ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ges 1 and 2 t of Health if itsm 27 i Sheon Dredden, Sr. Brother 624 Kahn Drive, Pikesville, Md. Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Xurial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny injury or once. 4 ☐Donation 5 ☐ Other (Specify) Mt. Carmel Cem. 8-2-05 Dundalk, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Baltimore, Md. 21202 lady 9 Warre March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Complications of Neck Injury /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, flary, eating to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a nonsequence of) death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. ned by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? as been signe 2 should be c \$ Records. 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of d. uh?

1 Yes 2 □ No 24a. Was an autopsy s certificate ha performed? 1X Yes 2 No Division of Vital 25. Was case referred to medical examiner?

1 🖾 Yes 2 🗆 No Be 26. Place of Death | Check only one | Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE 1 Inpatient 2 ER/Outpatient 3 DOA this After this Date of Injury (Yonth, Day Year) 28d. Describe how injury occurred unk 27. Manner of Death Find ime of unk 28c. Injury at Work? Certification: ial or Ah.

Turs after dean

I Director: Ah.

in by the fer-1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 9:50 A 8-2005 6 X Could not be determined 3 🗌 Suicide Park (Street and Number of Byral Route Numbe Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in Scene 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 29, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel F Arithall WAN 111 Penn Street, Baltimore, Maryland 21201 0 Pamela E. Duthath MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Physician Decedent's Name (First, Middle, Last) Jonathan E. Dempsey 2. Date of Death Day July 27 2005 10:55 2. Decedent's Name (First, Middle, Last) July 27 2005 10:55 2. Decedent's Name (First, Middle, Last) July 27 2005 10:55 2. Decedent's Name (First, Middle, Last) July 27 2005 10:55 2. Decedent's Name (First, Middle, Last) July 27 2005 10:55 2. Decedent's Name (First, Middle, Last) July 27 2005 10:55 2. Decedent's Name (First, Middle, Last) July 27 2005 10:55 2. Decedent's Name (First, Middle, Last) July 27 2005 10:55 2. Decedent's Name (First, Middle, Last) July 27 2005 10:55 2. Decedent's Decedent July 27 2005 July	
Physician Jonathan E. Dempsey July 27 Yoar 2005 10:55 A	
## A. Facility Name (if not institution, give street and number) 2309 Callow ## County of Death N/A ## Social Security Number 2309 Callow ## Social Security Number 5. Social Security Number 5. Social Security Number 6. Sax 10X 2 F 7. Age (in yrs. last birthday) Worth Days Hours 7. Age (in yrs. last birthday) Worth Days Hours 102	
Funeral Director Funeral Besidence of Decedent 100. State 100. County 100. City, Town or Location 100. City, Town or Location 100. City, Town or Location 100. State 100. County 100. City, Town or Location 100. State 100. County 100. City, Town or Location 100. State 100. County 100. City, Town or Location 100. State 100. County 100. City, Town or Location 100. State 100. County 100. City, Town or Location 100. State 100. County 100. City, Town or Location 100. State 100. County 100. City, Town or Location 100. State 100. County 100. City, Town or Location 100. State 100. County 100. City, Town or Location 100. State 100. County 100. City Town or Location 100. State 100. County 100. City Town or Location 100. State 100. County 100. City Town or Location 100. State 100. City Town or Location 100. State 100. City Town or Location 100. State 100. City Town or Location 100. City, Town or Location 100. City Town or Location 100. City Town or Loc	7
Director Director	
Usual Residence of Decedent 10a. State 10b. County Maryland Carroll 10e. Street and Number 11. Marital Status 11. Marital Status 11. Mover Married 2 Married 3 Wickowed 4 Divorced 11. Specify: White 11. Mover Married 2 Married 3 Wickowed 4 Divorced 10. Specify: White 11. Mover Married 2 Married 10. Specify: White 12. Was Decedent Ever in U.S. Armed Forces? 11. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, Specify: White 11. Mover Married 2 Married 10. Specify: White 11. Mover Married 10. Specify: White 12. Was Decedent Ever in U.S. Armed Forces? 11. Mover Married 10. Specify: Specify: White 11. Mover Married 10. Specify: White 12. Was Decedent Usual Occupation (Give kind of working life. DO NOT use retired) 12. Mover Married 13. Was Decedent Usual Occupation 14. Base - American Indian, 18. Kind of Business/Industry 16. Specify: White 16. Kind of Business/Industry 16. Kind of Business/Industry 16. Specify: White 16. Kind of Business/Industry 16. Docadents Usual Occupation 16. Give kind of working life. DO NOT use retired) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surmame) 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 12. Name and Add	reign
The state of the s	imits
The state of the s	
The state of the s	
The state of the s	
The state of the s	
The state of the s	
Edward Affeegorchik	
Edward Ay/Gregorentk	
Davided 117 decorrection 207 frederick toda Daterijore. Pip 21220	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwee	n
Physician Immediate Cause (Final disease or condition Narcotic Intoxication	ah
/Medical resulting in death) Due to (or as a consequence of):	
Sequentially list conditions, Due to (or as a consequence of):	
Sequentiafly list conditions. The property of	
that initiated events ' resulting in death) Last	
difficate be as the buyers are the buyers are the buyers are the buyers are the buyers as the buyers are	
Cause. Enter Underrying Cause.	
February 1 February 23d. Date of delivery 23	
So that the part of the part o	
24a. Was an 24b. Were autopsy findings ava	lable
The state of light of	e of
The second of th	
The second of th	ene
27. Manner of Death 1 Natural 2 Accident 3 Solicide 4 Homicide 282. Injury at Work? 7/27/2005 10:46 a M 1:282 284. Date of Injury 4 Produity 1 Solicide 4 Homicide 285. Time of Produity 1 Solicide 4 Homicide 286. Injury at Work? 7/27/2005 10:46 a M 1:282 286. Describe how injury occurred 1 Solicide 4 Homicide 286. Injury at Work? 7/27/2005 286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 10:46 a M 1:282 286. Location (Street and Number of Rural Route Nu	
3 Suicide 4 Homicide 3 Suicide 4 Homicide 3 Suicide 4 Homicide 5 Could not be determined determined 5 Description 5 Description 6 Description 7 Description 6 Description 7 Description 6 Description 7 Description 6 Description 7 Description 6 Description 7 Descript	
found in vacant house Baltimore, MD	=
25. Was case referred to medical examiner? 1	
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
Larol Hallan und OCME July 28, 2005	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHOL HAVAN WA 111 Penn Street Baltimore, MD 21201	
State Registrar ALIG 0 2 7005 32 Registrar's Signature	

amend item#15,18, perFh, 6846, 8/2/05 III
State of Maryland / Department of Health and Mental Hygiene
Amend item 11 per fh/2s 846 8-17-05 vt

Reg. No. 10 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Frank Prescott Dawson, Jr. 7:40 p. July 26, 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Burtonsville Montgomery County Holy Cross Nursing Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days 1 X M 2 ☐ F 352.16.2938 80 Director September 18, 1924 Illinois Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f shov the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Howard Ellicott Clty 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21043 U.S.A. 3400 North Ridge Rd., Apt. 801 Items 23a by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Anned Forces?

14 Yes 25 Hold Hyes Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 Yes 2 No Specify: Specify: Black State owed 4 □ Divorced WII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry US Dept. of Labor than College (1-4or 5+) 4+ Il Hygiene. other than Elementary/Secondary (0-12) Manpower Development Specailist permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg Important: If tem 27 is marked other any njury or other traumant. other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Johnson Frank P. Dawson Katherine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Frank P. Dawson, III 6918 Garland Lane Columbia, Maryland 21045 Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Christ Episcopal Church Cemetery 07/30/2005 Columbia, Maryland 21. Sonature of Funeral Service Licens 22. Name and Address of Facility studiellen Slack Funeral Home, P.A. mous 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** stacie Cardiomyopath unknown resulting in death) /Medical Due to (or as a consequence of): Examiner Market Market Law Monic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit noestive unknown and Die to (on as a consequence of): P.O. Box 68760, detached for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, the funeral director, page 2 should be 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an certificate has 2 No 1□ Yes 1 Yes 2 ₽No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 3□ DOA 2 FR/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) lilled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20034726 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7616 Mussema Rd., Bethesda, HD 20317 SIMINE Gasti m 32. Registrar's Signature All G () State 2 AND STORES Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Justus William 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Chestertown Point of Chestertown
If Under 1 Year | If Under 24 Hrs. Kent MD Heron 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Birthplace (State or Foreign Country) Days 1**⊠**M 2□F Q. 221-03-0198 Mich Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No CHESTERTOWN **KENT** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21620 501 E CAMPUS AVE 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes 2 ☐X No Specify Specify: 3X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CHEMICAL COMPANY **PURCHASING** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) IRENE WHITNEY WILLIAM CLIFTON EDDY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CONSTANCE BARRAS/ DAUGHTER P.O. BOX 1296, RANGELEY, ME 04970 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 8-1-05 ALEXANDRIA, VA 22. Name and Address of FacilityFLECK FUNERAL HOME, INC. 21. Signature of Pineral Service Licensee 7601 SANDY SPRING RD, LAUREL, MD 20707 23a Part1. Enter the disease, or consnock, or heart failure. List only perications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, yone cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of). Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PERIPHERAL VASCULAR Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably DIABETES MELLITUS 24a. Was an autopsy performed?
1 Yes 252 No 24b. Were autopsy findings available prior to completion of cause of death? DEMENTIA 1 ☐ Yes 25 No

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

238

or Items

"natural",

permit. Pages 1 and 2 should be filled v Department of Health and Mental Hygies Important: If item 27 is marked other tt any Injury or other traumatic event. IIIs once.

the Medical Examiner must be notified at

Funeral Director

ģ

Completed

Be

MD

with the Maryland

filed within 72 hours after death

Maryland 21215-0036

Baltimore,

Examiner physician and s the burial-transit Box 68760. as use : P.O. Records, Division of Vital the Hospital or Attending Physician: Certification: After

Be Completed by Physician/Medical 25. Was case referred to medical examiner?

10

within 24 hours a

Registrar

Medical

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier

investigation 6 Could not be determined

5 Pending

28a. Date of Injury (Month, Day Year)

D0041587

Other:

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

26. Place of Death Check on one

Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. Noble Helen Ray, Year) 31. Date filed (Month,

AUG 0 2 2005

1 ☐ Yes 2 No

27. Manner of Death

Natural 2 Accident

3 Suicide

122 Speer Rd 327 Registrar's Signature

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Suite 5, Chestertown, MD 21620

			For State Registrar	State of Ma	aryland /			nt of Hotel		ınd M		giene Reg. No	2005	25	099
П	Physici	_	1. Decedent's Name (First, Middle, Las Charlotte B.	Fder							2. Date of De.	Day	Year 200	. 1.	ne of Death
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location o	f Death		4c.	County of Dea	29	<u>и</u> / і
			Union Memorial Ho					altin					ltimor	e Cit	У
	Funeral Director		210-24-2006	9x 7. Age □ M 2⊠ F	76	irthday) Yrs.	Months Months	r 1 Year Days	If Under 2 Hours	Min.	8. Date of Bin MAR 2,	1929	9. Bi	rthplace (S ountry)	tate or Foreign
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	wn or Lo	cation							10d. Insi	de City Limits
	Mary a-f sh	tor	MD N/A		Balt	imor	:e							11	Yes 2 □ No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23e or 28e-f show if item 27 is marked other then "natural", or items 2 is not 10 in a nother treumstic event, the Medical Evan it are must be notified at	Funeral Director	10e. Street and Number 3802 Glenarm Aven	ue			10f. Zip	2120)6			10g. Citiz USA	en of What C	ountry?	
	iter deat	-uner	11. Marital Status 1 □ Never Married 2 ☑ Married	12. Was Decedent I Armed Forces? 1 Yes 2 X		13. \	Was Dece f Yes, spe	dent of His cify Cubar	spanic Orig n, Mexican	in? (Spe , Puerto	ecify Yes or No Rican, etc.)	- 1	4. Race - Am Black, Wh		an,
5-0036	hours a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:				2 🔀 No						white	
215-	n "nat	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	de completed)		a. Deced (Give lite. l	ient's Usu kind of wo DO NOT u	al Occupa ork done di ise retired)	tion uring most	of work	ng	16b. Kir	nd of Business	s/industry	
212	filed within Hygiene. ther then "t	Com	12	College (1-4or 5		omen	aker					Ow	n Home		
	be filed ttal Hygi d other event, t	Be	17. Father's Name (First, Middle, Last)	D 1 -							(First, Middle,		Sumame)		
Maryland	should be ind Mental marked o umatic eve	٦	Charles Cole 19a. Informant's Name/Relationship (7)	Butler	10	b. Mailie	- Address	(Ctroot o	Mar:		Skarda Il Route Numbe		Town Chair	Tin Codel	
Ma	od 2 sho lith and I 27 is me r treums		Robert L. Eder -								altimor	-			
re,	es 1 and 3 of Health fitem 27 r other tr		20a. Method of Disposition		20b. Place of	of Dispo	sition (Na				arcinor		cation - City o		te
imo	Page ment cant: If ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Removal from State)	Chesape	-	-	-	· I	/2/2	005	Belt	sville	• MD	
Baltimore,	permit. Pages 1 and Department of Health important: If Item 27 any injury or other tr once.		21. Signature of Funeral Service Licen	see MC	00986	22	Name ar	nd Address	of Facility	1	hrmann Drive			-	286
	Physician /Medical Examiner (the privat-transit	dicai Examiner	23a. Part1. Enter the disease, or composition shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as c.	a consequence	of):	oca Ar Fai	rdi ter iluri	y P	Int Vise	farch)	on		Onset 9	days days days
.O. Box 68	The law requires that the death certifica te has been signed by the attending ph agge 2 should be detached for use as th	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 12 No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		Ectopic p					2	3d. Date of de Month	livery Day	Year
ds, P	uires that signed b	d by PI	Part II. Other significant conditions of	ontributing to death be	ut not resulting	in the ur	nderlying o	cause give	n in Part I.			obacco us res 2 [se contribute t		of death?
		Complete									24a. Was autop perfo 1 \sum Yes	sv	24b. Were a prior to death?	completion	ings available of cause of
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only o				
o	ਦੂ ≑ <u>'</u> ਬ	J: To	1 Yes 2 No 27. Manner of Death	1 Vinpatie 28a. Date of Injur (Month, Day		Time of		28c. Injury Work	4 🔲 1901		ne 5 Resid 28d. Describe h			ecify)	
ion	Attending Phyrdeath. actor: After thi by the funeral	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Year)	Injury	М		? es 2□N	lo					
Division	I or Attendest efter desti Director: d in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	iry - At home, f :. (Specify)	arm, str	eet, factor	y, office			28f. Location (5 City or Tox	Street and vn, State)	Number or A	ural Route	Number,
	To the Hospital or Attenwithin 24 hours effer deati To the Funerel Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Ph 2 Medical Exam	ysicien: To the best of the best of the basis of and manner sta	examination at	je, death nd/or inv	occurred restigation	at the time	e, date and inion, deat	place, a	and due to the o	cause(s) a date and	and manner a place, and du	s stated. e to the cau	JS8(S)
	To the within To the comple	Me	29b. Signature and title of certifier				290	c. License	number		,	29d. Date	signed (Mon	th, Day, Ye	ar)
	1		1 genne	i Pfa	m, 1	MI	> A	Ta	438	94	6	Ju	143	0. 2	2005
Ç	5		30. Name and address of person who	empleted cause of de	eath (Item 23a)	(Туре,		1100	Me	mo	nal	1.4	Soit	rs I .	MID
	Sta Registr		31. Date filed (Month, Day, Year) ALIC 0 2 200		ur's Signature	A	٠. م	* • V *				 	2.1		

			State of Maryland / Depa State of Maryland / Depa State of Maryland / Depa Cen	rtment of Health and Me tificate of Death		2005	25100
	-		Decedent's Name (First, Middle, Last)	2	. Date of Death		3. Time of Death
	Physici /Medic	_	Ronald Thomas Eagleston		July 31,	2005 Year	4:00A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	4c. County of Death	
			9608 Tiberias Drive	Upper Marlboro		Prince Ge	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Yrs.	Months Days Hours Min.	Date of Birth (Month, Day, Yea		place (State or Foreign
	Director		217 46 9781 XX 59 Yrs. Usual Residence of Decedent		March 7,	1946 Was	hington DC
	yland		10a. State 10b. County 10c. City, Town or Loc	ation		1	10d. Inside City Limits
	a-fs	ctor	Maryland Prince George's Upper Ma	rlboro			1 ☐ Yes 2 📆 💢 o
	or 28	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Cour	ntry?
	ath w		9608 Tiberias Drive	20772		United St	
	er de Item	Funeral	Armed Forces? If	/as Decedent of Hispanic Origin? (Speci Yes, specify Cuban, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Americ Black, White,	
36	Irs aft	by	1 ☐ Never Married 2 ⚠ Married 1 ☐ Yes 3 ☐ No If Yes, Give A 1 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	☐ Yes 2√xNo Specify:		Specify: Wh	ite
21215-0036	J within 72 hours after death with the Maryland jien. Jien. Than "natural", or Items 23a or 28a-f show the Madical Examiner must be notified at	ted		ent's Usual Occupation	16b.	Kind of Business/In	dustry
218	within 7 ene. than "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of working O NOT use retired)	'		
21	filed wi Hygien sthar th	S	12 Atto			aw	
Maryland	ed fa	Be	17. Father's Name (First, Middle, Last) Bernard Edwin Eagleston	18. Mother's Name (,	
2	should be and Mental I marked o	2		g Address (Street and Number or Rural I	igney Ker		Cadal
Ma	and 2 sho ealth and n 27 is m						
ē,	Tea tha		20a. Method of Disposition 2 Democratics State Community, crem	Tiberias Drive, Un	te 20c.	Location - City or To	own, State
Ë	Pages nent of int: If Its iry or o		I Duliai 2 M Vigitation 3 Divalitoral from State	atory Aug 1, 2005	C1	inton. MD	
Baltimore,	permit. Pages Department of I Important: If Its any injury or o			Name and Address of Facility Lee			
<u> </u>	99 = 5 8			lexandria Ferry Rd			
			23a. Part 1. Enter the disease of complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	or the mode of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ancer			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
Н		je l	Sequentially list conditions, b. Due to or as a consequence of :	· · · · · · · · · · · · · · · · · · ·			
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events				
o,	exect an and rial-tra	Exa	resulting in death) Last Due to (or as a consequence of):				
8760,	the death certificate be executed y the attending physician and tched for use as the burial-transit	dlcal	d				
9	ing ph e as th	Med	IF FEMALE:				
Вох	eath certific attending p	lan/	23b. Was decedent pregnant 1 2:3c. If yes, outcome of pregnancy 1 1 Live birth 2 Fetel death 3	Ectopic pregnancy		23d. Date of deliver	ery Day Year
0	the de by the a	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)			
Δ.	res that tigned by		Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacc	o use contribute to t	he cause of death?
Records,	The law requires that ite has been signed b bage 2 should be deta	d by	Hypotension		1 🗆 Yes	2 □ No 3 Prot	oably 4 Unknown
S	s been si	olete	. , ,		24a. Was an	24b. Were auto	opsy findings available
Re	The lav	Completed			autopsy performed	? death?	mpletion of cause of
Vital	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?	26. Place of Death (
of V	Physician: this certific ral director,	To I	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient		e 5 Aesidence	6 ☐Other (Specif	у)
no	ing After une	on:	27. Manner of Death 1 Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	ld. Describe how in	njury occurred	
Division	Attanding r death. ector: After oy the fune	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stre	M 1 Yes 2 No	of Location (Street	and Number or Rura	al Route Number
Di∨	i i i	Certification:	4 Homicide determined building, etc. (Specify)	set, factory, office	City or Town, St	ate)	ii i iodio i dinbor,
	To the Hospital or within 24 hours afte To the Funaral Director completely filled in the Funaral Director of the Funara Director of the		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, an	d due to the cause	e(s) and manner as s	tated.
	he Ho he Fu pletely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or invalid	estigation, in my opinion, death occurred	at the time, date	and place, and due to	o the cause(s)
	To t To t	₹	29b. Signature and title/of contitier	29c. License number	29d.	Date signed (Month,	Day, Year)
ŧ	4		H. Trahewee as	D005299	9	8/1/5	,
6	7		30. Name and address of person who completed cause of death (Item 23a) (Type, I		C:10/-	nn/ M.	12073
	Sta	nte.		PREATTY POAD	CLIMI	OIA MALÍ	20735
	Regist		31. Date filed (Month, Day, Year) — 32. Registrar's Signature	parke			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Breaunna Floyd UNK 05-05023 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar NJM Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month July 2005 1321 aunna /Medical acility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 913 Foxridge Lane If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day Baltimore Essex 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Funeral Months Days 1□ M 2**X**F **218-35-487**Usual Residence of Decedent Director 10a. State 10b. County City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Completed by Funeral Director more 10g. Citizen of What Country? 10f. Zip Code 'naturel', or itema 23a filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. 5 (do dary (0-12) College (1-4or 5+) Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Be ie marked of Pages 1 and 2 should be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, if item 27 i d of Disposition 5 1 Burial 2 Cremation 3 Removal from State Depertment of important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) saltimore, 21. Signature of Funeral Service Licensee Services 10 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** and Sharp torce Inquires Blunt /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours attent death.

To the Funerist Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Due to (or as a consequence of): Box 68760 Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Day Month 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2X No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1∠ Yes 2□ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 🖾 Other (Specify) 1 Yes 2 □ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Scene 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Forme 20 P 2 X No subject assaulted 125/05 1 🗌 Yes 2 Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

RESULVE Location (Street and Number or Rural Route Number, City or Town, State) G/3 Processing Control of the Control o FoxvidgeLu 16 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME July, 26, 2005 death (Item 23a) (Type, Print) Perale ST . Registrar's Signature State 2005 Registrar

			1 - For State Registrar	State of M	larylan		rtment tificate				-	giene Reg. N2	005	25102
	Physici		Decedent's Name (First, Middle, Last)		ma C.	Ford		-	-		2. Date of De Month	Day Day	200	ar S 20:40 PM
	/Medic Examin		4a. Facility Name (If not institution, give union Memorial Hos		7)		4b. City, 1	_	Location o			4c. C	ounty of D	
	Funeral Director		213 20 1041	7. A	ge (In yrs. I	ast birthday) O Yrs.	tf Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir Month, Da Feb. 7	th 19, Year) 192	9.	Birthplace (State or Foreign Country) Maryland
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City	r, Town or Lo	cation timor	·e						10d. Inside City Limits 12€Yes 2 □ No
	with the	Funeral Director	10e. Street and Number				10f. Zip		011			10g. Citize	en of What	
	death v	nerai	1338 Berry Street 11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.	S. 13.	Vas Deced		211 spanic Ori	gin? (Spec	cify Yes or No lican, etc.)	D- 14		USA umerican Indian,
9600	72 hours after death with the Maryland 'naturel', or liems 23a or 28e-f show disul Examinar must be notified at	þ	1 ☐ Never Married 2 ☐ Married **To Widowed 4 ☐ Divorced	1 Yes 2 X If Yes, Give Year or Dates:	X o		Tes, spec I⊡Yes 2		Specify:		ilcan, etc.)		Btack, V Specify:	white, etc. white
21215-0036	d within giene. r then "	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12	cation e <i>completed)</i> College (1-4or	5+)	16a. Deced (Give life. I	kind of wor DO NOT us	k done a e retired,	lu <i>ring m</i> os)	t of workin	g	В	Baltin	oss/Industry nore City L System
Maryland	should be filed ind Mental Hygi i marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) Henry Boss								(First, Middle Niede			
	d 2 sh th and th and 7 is m treum		19a. Informant's Name/Relationship (Ty Roland Ford (S	рө, Print) on)		19b. Mailin					Route Numb	-		e, <i>Zip Code)</i> 21784
Baltimore,	Pages 1 an nent of Heal int: If item 2 iry or other		20a. Method of Disposition 1XXBurial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State	_ Ce	lace of Dispo emetery, cren oodlaw	natory or ot	her place		Da 7/30/	ite	20c. Loca	ation - City	or Town, State , Maryland
Balti	permit. Pe Departmen Importent any injury		21. Signature of Eurleral Service License	- Cup	the	- 22 B	Name and urgee	d Addres -Hen	s of Facilit	eitz d Ba	Funera 1timor	1 Hom	ne, In	nc. nd 21211
	Pnysician /Medical		23a. Part1. Enter the disease, by complishock or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	SEPS	SIS	. Do not ent	er the mode	of dying	g, such as	cardiac or	respiratory a	rrest,	1 y 1 (1)	Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury		s a consequ L PE s a consequ	ience of): RFOT ience of):	CATI	'ON	,					3WK
8760,	sate be executed obysician and the burial-transit	dicai Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	21AU s a consequ KAL	CAN pence of): EFF	CER	E/1	NET,	ASI	ATK	<u> </u>		6 MO
.O. Box 68	death certific e attending p d for use as I	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ NO 9 □ Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal	death 3	Ectopic pre					23	d. Date of Month	delivery Day Year
٩	es the	by	Part II. Dther significant conditions con HYPERTENSION	ntributing to death	but not resu	ilting in the ur	nderlying ca	ause give	n in Part I.			obacco use	_	e to the cause of death? Probably 4 _Unknown
Vital Records,	he law e has b age 2 si	Completed	COLONARY ART	ERTY	DI	SEA	SE				24a. Was auto perfo		24b. Were prior death	autopsy findings available to completion of cause of 17es 2 1 No
Vita	certific rector,	Be	25. Was case referred to medical examiner?	lospital:				Othe			(Chack only o	one)		
of	ling After une	tion: To	1 Yes 2 No 27. Manner of Death 1 Phatural 5 Pending 2 Accident investigation	1 Linpat 28a. Date of Inj (Month, Da	ury	ER/Outpatien 28b. Time of tnjury		Bc. Injury Work	at	28	e 5 🗌 Resi 3d. Describe			Specify)
Division	- 0 -	Certification:	3 Suicide 6 Could not be determined	28e. Place of In building, e	njury - At ho etc. (Specify	me, farm, str	eet, factory,	, office		28	Bf. Location (City or To		Number o	Rural Route Number,
	To the Hospitel o within 24 hours aff To the Funerel Di completely filled in	edical	29a. Certifier 1 — Certifying Physical Check only one)	sicien: To the besiner: On the basis and manner s	of examinat	wledge, death ion and/or inv	occurred a restigation,	at the tim in my op	e, date an inion, dea	d place, ar th occurred	nd due to the d at the time,	cause(s) a date and p	nd manne lace, and	r as stated. due to the cause(s)
	With With Com	Σ	29b. Signature and jule of certifier	But	el	le	29c.	License	number	0		29d. Date	signed (M	onth, Day, Year)
	13		30. Name and address of person who co	mpleted cause of	death (Item	23a) (Type,	Print) Y	mic	nae	1 5	2110	YN	D	
	Sta Registi		31. Date filed (MorA) Pay, Year) 201	32/Aegist	trar's Signat	yre do	arte							

					State of M	aryland		artment of <i>rtificate of</i>	Hearrn and i <i>Death</i>	мептат ну	giene Reg. No	05	25102
	Di vivi		1. Decedent's Name	e (First, Middle, La:		0 =				2. Date of De		Voor	3. Time of Death
7	Physicia /Medic		MIE)SHE		OR	11			7	26	Year	11:25 A.M
1	Examin	er	4a Facility Name (II	1	e street end number)	>iATI	pic +	TOSP	4b. City, Town, or I	Location of Deal		ty of Death	MORE
	Funeral Director		5. Social Security No. 218 47 5	umber 6. S			ast birthday) Yrs.	If Under 1 Yea Months Days				9. Birth	place (State or Foreign ntry) Georges County
	pue M.		Usuel Residence of 10a. State	Decedent 10b. County		10c. City	, Town or Lo	ocation		J			10d. Inside City Limits
	Meryl Pf sho	to	MD	Baltimore			Dondo	l1stown					1 ☐ Yes 2 No
	th the	irec	10e. Street and Nun	nber		1	Kanga	10f. Zip Code			10g. Citizen o	f What Cou	ntry?
	s 23e	rail		nlee Road	10.111	- · · · · ·		2113			USA		
21215-0020	s 1 end 2 should be filed within 72 hours efter deeth with the Meryland if Heelth and Mentel Hygiene. Item 27 is marked other than "natural", or Hems 23e or 28e-f show other traumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 ☑ Never Marri 3 ☐ Widowed	ed 2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	?		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 No	Hispanic Origin? (S ban, Mexican, Puert Specify:	pecify Yes or Note Record (1997)	Spec	ace - Ameri lack, White, cify: Afr	
5-0	72 ho	Completed	(Spec	15. Decedent's Ed	lucation de completed)		16a. Dece (Give	dent's Usual Occu	upation e during most of wor ed)	rking	16b. Kind of	Business/In	dustry
121	within ene. than	dm	Elementary/Secon Special Educ		College (1-4or	5+)	-		ed)		Stude	nt	
	e filed with I Hygiene. other than	Be Co	17. Father's Name (5	tudent	18. Mother's Nar	me (First, Middle			
ylar	should be and Mentel marked o	일	Bobby Forte	ı		-			Jacqueline				
Maryland	d 2 sho h end 7 is m		19a. Informant's Na Jacqueline H		Type, Print)			35	at and Number or Ru			ın, State, Ziy	o Code)
	s 1 end f Heelth tem 27 other tr	-	20a. Nethod of Disp			20b. Pla		osition (Name of matory or other pl	l Randallsto	Date Date	20c. Location	n - City or Te	own, State
<u>m</u>	Pegenent of			☐ Cremation 3 ☐ 5 ☐ Other (Specif)	Removal from State			1 Cemetery		3-2-05	Laurel,	MD	
Baltimore,	permit. Peges 1 end Depertment of Heelth Important: If Item 27 any Injury or other tt once.		21. Signature	neral Source Licen	ISOO AND	11	2	2. Name and Addi	ress of Facility Wy	lie Funer	al Home	P.A. of	Balto. Co
	00500		Mon	11/1/			,		Road, Randa				
*	Physician		282 Part 1. Enter the shock, or hear	t failure. List only	plications that cruse one cause on each I	d the death. ine.	. Do not en	ter the mode of dy	ring, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
Haring the	/Medical		Immediate Ceuse (Final n	. CARD	IORF	SPI	Q A 70	RY FA	iLUR	F	į	
	Examiner		resulting in death)			Due to (or	as a conse	quence of):		—			
	uted d ansit	Examiner			b. SEVER		as a conse		LUNG D	>17F	AST		
ó,	The law requires thet the death certificete be executed et es been signed by the attending physician end pege 2 should be deteched for use es the bunel-trensit		Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or that initiated events	mediate rlying	BRON			1A-51S	IMM	runo.	SUPPI	2 EST	F)
68760,	sete be ohysici the bu	edical	that initiated events resulting in death) L		C.	Due to (or	as a consec	quence of):	/			i	
	certific ding p			L	d.PANRE	5157	ANT	PSEUL	somen.	AS IR	ACHE	E1713	
. Box	death e atter	iciar	Part II. Other aignifi	icant conditiona o	ontributing to death b	out not resul	tting in the u	APN	Eumb eiven in Part I.		tobacco use	ontribute t	o the cause of death?
P.0	v requires thet the death certifi been signed by the attending should be deteched for use et	Completed by Physician/N	RILIAD	Y ATD	FCIA	10/14	- 711	FRF	A11:10		Yea 2 No		
	signed d be d	b S	010 -	11111	-0		1-0	, a		240 100	an autopsy	24h W	ere autopsy findings
COL	v requ been shoul	ie tec	SIP IN	10 LIV	the 11	RAI	NZF	LAN		perf	ormed?	av cc	vailable prior to ompletion of cause death?
of Vital Records,	sicien: The law certificete hes b director, pege 2 s	E O	TRACH	FOM A	LACIA	182	Aco	470570	MY DEF) 10	Yes 2 No		☐Yes 2☐No
/ital	ystcian: The l is certificete he director, pege	Be C	25. Was case referr examiner?	+	6// (//)	1	ri Cil	0041	26. Place of Dea		one)		
of \	Attending Physician: or death. ector: After this certific by the funerel director.	은	1 ☐ Yes 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	NO	Hospital: Inpati	-	R/Outpatie	IL 3LI DOA		lome 5 ☐ Res	idence 6 🗆 C		fy)
	th. th. After funer	lg l	1 Natural 2 Accident	5 Pending investigation	28a. Date of Inju (Month, Da	y Year)	Injury	W	ork? □Yes 2□No	200. Describe	now injury occ	uneu	
Division	To the Hospital or Attending Phys within 24 hours efter death. To the Funeral Director: After this completely filled in by the funeral di	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of In	jury - At hor tc. (Specify)	me, farm, st	reet, factory, office	9		(Street and Nur wn, State)	mber or Run	al Route Number,
Ω	pital cours elected illed i	2	29a. Certifier	X Certifying Ph	ysician: To the best	of my know	dedae deat	h occurred at the	time date and place	and due to the	causo(s) and	mannor ac c	tated
	To the Hospital or within 24 hours efter To the Funeral Director Completely filled in	edical		2 Medical Exam	niner: On the basis of and manner st	t examinati	on end/or in	vestigation, in my	opinion, death occu	rred at the time	date and place	e, and due t	o the cause(s)
	To the vithing to the complete	ž	29b. Signature and	title of certifier	1/			29c. Licer	nse number		29d. Date sign		
	4		1/10	Ulm	2	m	1	D	41411		1-1	(6-	2005
	1		30. Name and addre	oss of person who o	completed cause of d	Death (Item	23e) (Type,	KIN7	ADE				
100	Sta		31. Date filed (Mont			rar's Signati	nte						
	Registr	ar	Λ	HG 0 9 28	105		10 1	- 49					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician July 29,2005 2:50 Juanita Ayleen Farmer-Catan /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Gilchrist Center For Hospice Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 □ M **2**CKF 61 Maryland Director 218-42-4946 8,1944 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location "natural", or itema 23a or 28a-f shov Liteal Examiner must be notified at 1 Yes XXNo Maryland Harford Bel Air Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1110 Vanguard Way, Apartment "A" U.S.A. 21015 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be fited within 72 hours after 1 ☐ Yes 2 ŽNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Baltimore, Maryland 21215-0036 Specify. þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) d other than "natu 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tavern Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Amanda Reinhardt Oliver Clifton Clayton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: if item 27 is any injury or other trace 25 Pioneer Ridge Drive, Port Deposit, Md. 21904 Lisa Vespucci (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard. Aug. 4, 2005 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addies of Facility Funeral Home, P.A. 21. Signature of Funeral Savie Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 that he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Cancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to influentiate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 pronths?
1 Yes 2 UNo
9 Unknown 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. À 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 1 Yes 2 (No 25. Was case referred to medical examiner? Physician: Be 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence Other (Specify) ٥ 1 Yes 2 No 2 EP/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours at To the Funeral D completely filled i 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and till of certifier

State Registrar

DHMH 17 Rev 1/2001

Registrar AUG 0 2 200

31. Date filed (Month, Day, Year)

w 15. Agordes

0601

ress of person who completed cause of death (Item 23a) (Type, Print)

S

32. Registrar's Signature

hartes St Tourson MO 21204

			For Stete Registrer	Stat	e of M	laryland	•	artmen tificate				ental Hy	_				
			Decedent's Name (First, Middle	e, Last)				imour				2. Date of De.	ath	' 0 () 5	23. Jime c	6.5
	Physicia		Dure1						0. W				Day 24	•	Year 05	3:30) P M
	/Medic Examin		4a. Facility Name (If not institution			r)		4b. City,	Town, or	Location of	of Death				y of Death		
			Washington Adv	entist	HOsp	ital		Tak	oma	Park			M	ont	gomer	v	
	Funeral		5. Social Security Number	6. Sex	7. A	ge (In yrs. la:	st birthday)	If Under Months		If Under Hours	24 Hrs. Min,	8. Date of Birt (Month, Da	th			place (State intry)	or Foreign
	Director		594-03-1380	1XC M 2[JF	56	Yrs.	WOTHERS	Days	Hours		06 20				maica	
	D S		Usual Residence of Decedent 10a. State 10b. County			10c City	Town or Lo	cation								10d, Inside C	ity Limite
	sho	'n				Too. Oily,	TOWN OF LO	Cation									2 🗆 No
	he N	Director	MD Princ	e Georg	ges	Ne	w Car						10- Citi		What Cou		
	a or i		8316 Oliver S	treet				10f. Zip					rog. Citi	USA		nuyr	
	7.72 hours after death with the Maryland "natural", or Items 23a or 28a-1 show coloul Extralment by motified at	Funeral	11. Marital Status		Deceden	t Ever in U.S.	13 \		784	ispanic Ori	igin? (Spe	cify Yes or No				ican Indian,	
	ter d	F.	1 Never Married 2 Mar	Am	ed Forces Yes 2	?	. 10.1	f Yes, spec	ify Cuba	n, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)			ck, White,		
2	urs a	by	3 ☐ Widowed 4 ☐ Divorced	. It Ye	es, Give r or Dates			1 ☐ Yes 2	2 □ x No	Specify:				Specif	^{fy:} B1	Lack	
21215-0036	2 ho	ted	15. Decedent's Education 16a. Decedent's Usual Occupation						ation	most of working			ind of B	nd of Business/Industry			
Ž	b. Bn "r	Be Completed	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0·12) College (1-4or 5+)														
2	filed within 72 Hygiene. other than "nai ent, Ire Modic				yrs		Te	chnic	ian				COM	.CAS	T Cab	ole Co	•
Maryland	0 m 5		17. Father's Name (First, Middle,	Last)								(First, Middle,	Maiden	Sumar	пө)		
<u>X</u>	should t	2	Nathaniel Ge	ntles						Vio	da Du	ıncombe					
<u>a</u>	es 1 and 2 should b of Health and Ment I item 27 Is marked r other traumatice		19a. Informant's Name/Relations	hip (Type, Prin	it)			-				I Route Numbe					
	and ealth m 27 her tr		Odessa Gentles	:/Wife		1001 01				St. No		rrollt	_				
altimore,	Pages 1 nent of H int: If ite iry or ott		20a. Method of Disposition 1 XBurial 2 Cremation	3 □Removal	from Stat	0.00	ice of Dispo netery, crer	sition (Nan natory or o	ne of ther plac	(e)		ate	20c. Lc	cation	- City or To	own, State	
Ē			' 4 ☐ Donation 5 ☐ Other (5			Par	klawn	Ceme	tery	7(08-01	L - 05	Roc	kvi	11e,	MD.	
Bai	permit. Departr Importa any Inju		21. Signature of Funeral Service	Licensee	an		22	l. Name an	d Addres	ss of Facilit	^{ty} Mar	shall'	s Fu	ner	al Ho	me	
_	4 C) 7 4 0		> Ma	yha								Washin		, D	.C. 2		
г	Physician /Medical Examiner		23a. Paft / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death														
			Immediate Cause (Final disease or condition resulting in death) Due to (or as(a consequence of):									Death					
ı																	
		er	Sequentially list conditions,														
	ed nsit	ulue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):														
	and and II-trar	Examln															
8760	cate be executed physician and the burial-transit	alE															
28		edlcal		d													
Rox	death certifi e attending I id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant			e of <u>pregnan</u>								23d. Da	ate of deliv	ery	
ň	d for	cla	in the past 12 months? 1							Month Day Year			Year				
O.	y th	hys	9 ☐ Unknown														
ري ت	The law requires that ate has been signed bage 2 should be deta	by P	Part II. Other significant conditions contributing to death but not resulting in the upderlying pause given in Part I. 23e. Did toba							obacco u	acco use contribute to the cause of death?						
ğ	w require been sig should b		End	policy	e U	محري	1	als	1	Q		10	Yes 21	Š No	3 Prof	bably 4 🗌	Unknown
Records,	s bee	Completed	Crans	2.4	1	Need	\mathcal{I}	7	00	~		24a. Was		24b.	Were auto	opsy findings	available
ř	sician: The law certificate has t irector, page 2 s	mo		7		, , ,						autor perfo	rmed? 21 No		death?	ompletion of o	cause or
Vita	an: 'tiffica tor, p	0	25. Was case referred to medica	il l				-		26. Place	of Death	(Check only o		1	103	2010	
\geq	ysici is cer direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital	1 🔀 Inpa	tient 2 E	R/Outpatien	it 3 DO	A Oth	er: 4 🗆 Nu	ırsing Hor	ne 5□Resid	dence	6 🗆 Oti	her (Speci	fy)	
T Of	ding Ph h. After th funeral																
<u> </u>	andir sath. or: Al	atle	Tablified S Pending 2 Accident investigation M 1 Yes 2 No														
Division	r Att	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		Place of I building,	njury - At hometc. (Specify)	ne, farm, str	eet, factory	, office			28f. Location (S City or Tox	Street an vn. State	d Numi	ber or Rura	al Route Nur	nber,
	ital or ris af ral D																
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	edical	29a. Certifier 1 N. Certifyi (Check only 2 Medicel	ng Physician: Examiner: On and	To the bes the basis manner:	of examination	ledge, death on and/or in	occurred vestigation,	at the tim in my o	ne, date an pinion, dea	nd place, a oth occurr	and due to the ed at the time,	cause(s) date and	and mal place,	anner as s and due t	stated. .o the cause(s)
	To the within To the comp	M	29b. Signature and title of certific	ir ((ı	29c		e number			29d. Dat	e signe	ed (Month,	Day, Year)	
	1			7		2			1	145	290			1- 2	25-0	ادر	
14	//		30 Name and address of person				23a) (Type,	Print)		1)	1 .	R			77	207,	1.5
	U		143CC,	COL			-ex	U	1	10	9	VSC	1.0			(2-)	/ /
	Sta Registr		31. Date filed (Month, Day, Year,		32. pegis	itrar's Signatu	k A	all I									

			1 - State Amend Item 8 State per 1. Decedent's Name (First, Middle, Last)	of Maryl fh G84	and / Depa 6 8-8-05 <i>Cel</i>	artmen tas <i>rtificat</i>	t of H e of L	ealth a Death				15	25107	
	Physici /Medi		Alfred K. Gladden				2. Date of Death JULY 31, 2005		Year	3. Time of Death 10:15 А. м				
	Examir	ier	2709 Southern Avenue Balt					Baltimore					4c. County of Death N/A	
	Funeral Director		5. Social Security Number 215-09-0052 6. Sex 10 M 2 F 87 Yrs. Social Security Number 215-09-0052 10 M 2 F 87 Yrs. Social Security Number 215-09-0052 8. Date of Birth 1-16-191 Firthplace (State Country) Min. Social Security Number 24 Hrs. Social Security Number 24 Hrs. Social Security Number 24 Hrs. Social Security Number 25 Min. Social Security Number 26 Hrs. Social Security Number 27 Hrs. Social Security Number 27 Hrs. Social Security Number 27 Hrs. Social Security Number 28 Hrs. Social Security Number 29 Hrs. Social Sec									place (State or Foreign ntry) land		
	ith the Maryland or 28e-1 show	Director	10a. State 10b. County Maryland N/A		. City, Town or Lo Baltimore	,							10d. Inside City Limits 1 Y Yes 2 No	
	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depirtment of Health and Mental Hyglene. Depirtment of Health and Mental Hyglene. Important: If item 27 is marked other than "netural", or Items 23a or 28e-f show any injury or other traumatic event. It a Modical Examiner must be nutilled at 2006.	eral Dire	2709 Southern Avenue 21214 USA											
900		þ	1 Never Married 2 Married 1 Yes	d Forces? es 2 17 No , Give or Dates:	'	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:					Blac	ek, White White	etc.	
21215-0036		Completed	15. Decedent's Education (Specify only highest grade comple) Elementary/Secondary (0-12) Colleger 2	ed) ge (1-4or 5+)	16a. Deced (Give life. L	kind of wor DO NOT us	k done d	urina most	of working		16b. Kind of Bu Eastern S			
Maryland		To Be C	17. Father's Name (First, Middle, Last) Clyde Gladden					^{18.} Mother Viola			Maiden Sumam	e)		
			19a. Informant's Name/Relationship (Type, Print) Mary Hood/Cousin		1607	Ruxtor	n Road	nd Number I Balt	imore	Maryland	r, City or Town, d 21214	State, Zij	o Code)	
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fi 3 ☐ Comparison 5 ☐ Control (Specify) Entor	om State Dment	b. Place of Dispo cemetery, cren Parkwood	Cemete	ther place Py	8	Da 3/5/05		20c. Location - Baltimore	,		
Bal			21. Signature of Funeral Service Licensee Christina L. Hilton Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 23a. Part I. Enter the disease, or complications that caused the death. So not enter the mode of dying, such as cardiac or respiratory arrest, App.										Approximate	
8760,	icate be executed XX physician and hybridian site burial-transit the burial-transit transit tr	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): d.											
O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months?	outcome of preve birth 2 Fregnant at time onknown	etal death 3 □	Ectopic pro					23d. Dati Mor		ery Day Year	
ecords, P.	w requires that been signed b should be deta	by	by	Part II. Other significant conditions contributing to death out not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of deat			
Division of Vital Reco	anding Physician: ath. br: After this certifica	Completed							_	24a. Was a autops perform	ped? d	rior to co eath?	psy findings available mpletion of cause of	
		To Be	To B	0 8	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 28e. P	ate of Injury Month, Day Year	At home, farm, stre	M	8c. Injury Work 1 \(\) Y	4 🗆 Nurs	sing Home 28	d. Describe ho	ence 6 Other	эd
Ö	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.		29a. Certifier ↑♥ Certifying Physician: To	the best of my	knowledge, death	occurred a	at the time	a, date and	place, and	City or Town	auso(s) and mar	ner as s	tated.	
	To the He within 24 To the Fu	Medical	(Check only 2 Medicel Examiner: On the and r. 29b. Signature and title of certified	nanner stated.	nination and/or inv		in my opi		occurred		ate and place, a			
)	15		30. Name and address of person who completed	cause of death (M. J. J. (Type, I	Print)	1/1	108	01	B	3/2/	10	5	
	Sta Registr		31. Date the (Marth Gay, Year)	Registrar's Si	gnature	Me s	6	135 V	17	[BA	TT /	ומן	2(237	

			State of Manyland / Don		lental Hygi	ene						
			1 - State Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg	Reg. N2 005 25 108						
	Physici		Robert Joseph Gerhardt		25 2005	3. Time of Death 10:05 A M						
	/Medio Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	th					
			Charlotte Hall Veterans Home	Charlotte Hall	Saint Marys							
	Funeral Director		5. Social Security Number 220-12-2831 6. Sex 1 ₹ 7. Age (In yrs. last birthda) 79 Yrs.	/ If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Pay,) 8/28/192	9. Birthplace (State or Foreign Country) MD						
	/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits					
	Se-fsh	Director	MD Anne Arundel Glen Bur				1 ☐ Yes 2 🔀 No					
	ba filed within 72 hours after death with the Maryland ital Hygiene. d other than "naturel", or Items 23a or 28e-f show event, the Medical Evertifier must be notified at	i Dire	10e. Street and Number 1029 Genine Drive	10f. Zip Code 21060	100	g. Citizen of What Co USA	ountry?					
		To Be Completed by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	. Was Decedent of Hispanic Origin? (Spi If Yes, specify Cuban, Mexican, Puerto	14. Race - American Indian, Black, White, etc.							
980			1 Never Married 2 Married 1 M Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: White						
2-0	72 ho		15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work	ina 16	6b. Kind of Business	Kind of Business/Industry					
Baltimore, Maryland 21215-0036	within iene. r than "		Elementary/Secondary (0-12) College (1-4or 5+) Tran	Potts & Callahan								
nd	ba filed htal Hygie od other event, u		17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		,					
ryla	permit. Pages 1 and 2 should ba Department of Health and Mental Important: If item 27 Is marked o any injury or other traumatic eve once.		19a Informant's Name/Relationship (Type Print) 19h Mai	Anne Stinchcomb								
, Ma			Mrs. Beverly Robin Wong/daughter 102	ling Address <i>(Street and Number or Rura</i> 9 Genine Drive, Gle								
ore				ematory`or other place)		oc. Location - City or						
ıltim			(4 □ Donation 5 🖾 Other (SpedMasusoleum Glen Ha	ven Cemetery 7/28		len Burni						
ä			I was gray	Second Ave SW Gle	n Burnie	MD 21061	me P.A.					
	Hospi 4 hou Funer ely fill		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final									
			disease or condition resulting in death) a. Due to (or as a consequence of):									
		<u>.</u>	Sequentially list conditions, b. Alzhline; duil									
<u> </u>		Examiner	Cause. Enter Underlying Cause (Disease or injury) that initiated events c									
8760,		Physician/Medical Exa	resulting in death) Last Due to (or as a consequence of):									
9			d									
Box				⊒Ectopic pregnancy		23d. Date of delivery Month Day Year						
P.0.		hysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown 9 ☐ Unknown	Other (specify)								
		To Be Completed by	Part II. Other significant conditions contributing to death but not resulting in the		the cause of death?							
Records,			Annia, Colony acting dit	24a. Was an	obably 4 Onknown							
Re					autopsy performe	prior to	completion of cause of					
Vital			25. Was case referred to medical examiner? Hospital: Hospital:	(Check only one)	y one)							
of			27. Manger of Death 28a. Date of Injury 28b. Time		lome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred							
Division of		catio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No								
DΙΧ		Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	, factory, office 28f. Location (Street and Number or Rural Route Num. City or Town, State)							
		Medicai C	29a. Certifier (Check only one) 1	th occurred at the time, date and place, a envestigation, in my opinion, death occurre	and due to the caused at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)					
	To the within 2 To the complet	Mec	one) and manner stated. 29b. Signature and title of certifier	29c. License number		. Date signed (Monti						
•	0.			D008/947	1 1	1/25/15	,					
	10		30. Name/and address of person who completed cause of death (Item 23a) (Type	harlotte Hall Ri	d chast	offe Hai	N 201022					
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 2 2005 37 Hegistrar's Signature	reles	(
	- registi	2.1	HOU OF FOOD BELLEVILLE TO THE									

		ļ	1 - For State Registrar	State of M			rtment of H		d Mental Hy	/gien	2005	25109
	Physici	an	1. Decedent's Name (First, Middle, L	ast)					2. Date of Do	eath Da	y Year	3. Time of Death
	/Medic		Hans Egon Hopp						July	2	9 2005	9:36 AM
	Examin	er	4a. Facility Name (If not institution, g.	ive street and number)			4b. City, Town, or	Location of De	eath		County of Deat	
			Doctors Hospital 5. Social Security Number 6.	Sex 7. Ac	ge (In yrs. last bin	thday)	Lanham If Under 1 Year	if Under 24 F	Irs. 8 Date of Bi	P	rince Geor	
	Funeral Director		579-76-6806	1 X □M 2□F	00	Yrs.	Months Days		in. 8. Date of Bi (Month, D. December	ay, Year	1915 Germ	nplace (State or Foreign untry) any
			Usual Residence of Decedent									
	show	_	10a. State 10b. County		10c. City, Town	n or Loc	ation					10d. Inside City Limits
	ith the Mi or 28a-f	Director	MD Prince G	eorge	Greent	pelt	T					1 ∕ Yes 2 □ No
	deeth with the Maryland rms 23a or 28a-f show r must be notified at	Dir	10e. Street and Number				10f. Zip Code				itizen of What Co	untry?
J.	ns 23	Funerai	3C Research Rd	12. Was Decedent	Ever in U.S.	13. W	20770	ispanic Origin?	(Specify Yes or N		JSA 14. Race - Ame	ncan Indian.
	after deeth w or Items 23a niner must b	Fun	1 Never Married 2 Married	Armed Forces?	2	1			(Specify Yes or Ne erto Rican, etc.)		Black, White	
5-0036	ours a	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	☐Yes 2ሺ No	Specify:			Specify: W	hite
2 0-5	within 72 hours after ane. than "natural", or Ite	Completed	15. Decedent's i (Specify only highest g		16a.	(Give k	ent's Usual Occupa	during most of v	vorking	16b. F	(ind of Business/I	ndustry
121	within ane. than	mp	Elementary/Secondary (0-12)	College (1-4or : 5+	5+)		O <i>NOT</i> use retired 1 Engineer)			F	
20	filed Hygid Sther	O e	17. Father's Name (First, Middle, Las					18. Mother's N	lame (First, Middle		Engineer	
an	id be ental kad c	To Be	Sally Hopp						Nee Herz		,	
ary	2 should be filled w n and Mental Hygier is markad other ti raumatic evant, Lu	-	19a. Informant's Name/Relationship	(Type, Print)	19b.	. Mailing	Address (Street a		Rural Route Numb	oer, City	or Town, State, Z	ip Code)
1 ≥	and 2 salth a n 27 is		Gloria A. Hopp/Wife					Greenbelt	MD 20770			
, Baltimore,	ges 1 and 2 should be filed within 72 hours after deeth with the Maryla it of Health and Mental hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-1 shot or other traumatic event, It a Medical Exeminations to nuffied at		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3	□Removal from State	cemeter	y, crema	tion (Name of atory or other plac	е)	Date		ocation - City or	
Ë	tment: tant: jury		*4 □Donation 5 □Other (Spec	ify)	месторо		Crematory		2-05		andria, Va	
Bai	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or othar tra		21. Signature of Funeral Service Lice	160					leck Funera		-	
			23a. Part1. Enter the disease, or co	mplications that caused	d the death. Do r				, Laurel, N		707	Approximate
			shock, or heart faiture. List onlinediate Cause (Final	y one cause on each li	ne.		l Fn					Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)		a consequence		~ 4 V	terco	NOZ			
	Examiner		Conventially list and dising	b. Prr	wth	<u>. </u>						
B	70 ≔	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence of	of):						
1.	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Dug to (or so	a consequence of	~ 6\.						
8760,	cate be executed physicien and the burial-transit	ai E		ode to (or as	a consequence (ы).						
687	tificate ig phys as the	edicai		d					<u> </u>			
Xo	eath certific attending p for use as	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date of deliv	very
m.	that the death cer ed by the attendir detached for use	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at	2 ☐ Fetal death t time of death		ctopic pregnancy Other <i>(specify)</i>				Month	Day Year
0.0	at the	hys	9 Unknown	9□ Unknown								
<u>ග</u>	signed d be det	by F	Part II. Other significant conditions		1 /	the und	derlying cause give	en in Part I.				the cause of death?
oro	w requires been sign should be	eted		Parel	rianci				- 11		□No 3□Pro	
Division of Vital Records, P.O. Box 6	or Attending Physician: The law requires that the death certificather death. Director: Atter this certificate has been signed by the attending p in by the funeral director, page 2 should be detached for use as	Completed							24a. Was		24b. Were aut prior to c death?	opsy findings available ompletion of cause of
<u>a</u>	n: Th ficate		05 Was a section of the last						1 Yes	2 X NO		2) No
\S	Physician: The I this certificate ha al director, page	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2 ER/Out	tnationt	3☐ DO∆ Othe		eath <i>(Check only</i>) Home 5 Resi		S □0th (S	4. 1
o	g Phy er this	n: To	27. Manner of Death	28a. Date of Inju	iry 28b. T	ime of	28c. Injury	at	28d. Describe			ny)
io	ath. r: Aft	atio	1 Natural 5 Pending investigati	on	ly rear)	njury	Work M 1□1	r res 2□No				
.≥	r Atterder de l'recte	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	289. Place of Inj	jury - At home, fai c. (Specify)	rm, stree	et, factory, office		28f. Location (City or To	Street ar wn, State	nd Number or Rui	ral Route Number,
Q	oital ours af	Cel	~	-					<u> </u>			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exe	hysician: To the best iminer: On the basis of and manner st	f examination and	, death o d/or inve	occurred at the time estigation, in my op	e, date and pla pinion, death oc	ice, and due to the curred at the time,	cause(s date an) and manner as d place, and due	stated. to the cause(s)
	o ths ithin 2 o the omple	Med	29b. Signature and title of certifier	and manner sta	ateu.		29c. License	number		29d. Da	ite signed (Month	, Day, Year)
	⊢ s ⊢ ŏ		> Thank	7			m005	3718		7	130/00	5
	1	0 3	30. Name and address of person who	completed cause of d	leath (Item 23a) (Туре, Р	rint)		. 1			
_	l		V 1110	550n 8119	8 Good	Luk		onham	mo. 8	1070	6	
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 2 201	62. Registr	ar's Signature	bort	م					
	negistr	ai	HUG (1 % 201	A SECTION ASSESSED.	-							

ATAT	HODDS		1 For State	State of	f Maryla	•	artment rtificate			1ental Hy	giene Reg. No 20	05	25110
8		1 %	1. Decedent's Name (First, Middle,	Last)			imodio	0, 00	ut//	2. Date of De	ath	00	3. Time of Death
180	Physici /Medic		Anne Elizabeth	Hobbs						JULY	30, 200	O5	2:15 P M
1	Examir		4a. Facility Name (If not institution,		m <i>ber)</i>		4b. City, To	own, or Loca	ation of Death		4c. Count		
			4 UPLAND ROAD					CIMORE				N/	
·	Funeral Director		5. Social Security Number 218-28-0173	i.Sex 1 ☐ M 2 🔀 F	7. Age (In yrs 73	: last birthday) Yrs.	If Under 1 Months		Jnder 24 Hrs. ours Min.	8. Date of Bir (Month, Da SEP 17	th y, Year) 1931	9. Birtho	place (State or Foreign ntry) MD
	pu ,		Usual Residence of Decedent		10.0								
	show	-	MD N/A		1	ity, Town or Lo Baltimo						1	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	28a-f	ecto	10e. Street and Number		1	Dartino	10f. Zip C	Codo			10g. Citizen of	What Cour	
	Mith Ba or	급	4 Upland Road,	#39				21210			USA	Wilat Coul	iti y :
	ms 2:	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in l	J.S. 13.			nic Origin? (Sp	ecify Yes or No Rican, etc.))- 14. Ra	ce - Americ	
36	72 hours after death with the Maryland natural, or items 23a or 28a-f show Esal Exandine must be nutfled at		1 Never Married 2 Marrie	Armed Fo	2 X No		it Yes, specif 1 ☐ Yes 21		exican, Puerto pecify:	Hican, etc.)	Special Specia	ck, White,	
Ö	72 hours natural;	d by	3 ☐ Widowed 4 🛣 Divorced	Year or D	ates:							WIII	
-5	in 72	olete	(Specify only highest	grade completed)		(Give	dent's Usual kind of work DO NOT use	done during retired)	g most of work	ing	16b. Kind of E	susiness/in	dustry
21215-0036	be filed within 72 ho ntal Hygiene. Id other than "natur event, the Michael	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		istrat				Financ:	ial /	Banking
Б	be filed ital Hygid of other event, I	Bec	17. Father's Name (First, Middle, La	ist)				18.	Mother's Nam	e (First, Middle,	, Maiden Sumai	m <i>ø)</i>	
yla	2 should be and Mental is marked c	<u>ا</u>	Thomas Hunt	Bratta	n				Eugen		rlong		
Maryland	s 1 and 2 should f Health and Mer ltem 27 is marke other traumatic		19a. Informant's Name/Relationship Thomas H. Bratta		her					Grove,	PA 19		Code)
re,	is 1 and 2 if Health Item 27 I		20a. Method of Disposition			Place of Dispo	sition (Name	e of	-	Date	20c. Location	- City or To	own, State
imo	Pages ment of i ant: If Its ury or o		1 ☐ Burial 2 ☒ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State _	sapeake (-		8/2/	2005	Belts	ville	, MD
Baltimore,	permit. Pages Department of Important: If I any Injury or once.		21. Signature of Funeral Service Li	censee	_ MOO9	22 086 C	AFA, S	Address of Stephe	Facility n D. Lo	ohrmann	, PA		MD 21286
			23a. Part1. Enter the disease, or or	omplications that of	caused the dea	ath. Do not ent	or the mode	een P of dying, su	'ASTURE: ch as cardiac	S Drive or respiratory a	, Baltır rrest,	nore,	Approximate
	Physician		shock, or heart failure. List or Immediate Cause (Final disease or condition		IOSCLEI	DOTTC C	\DDT∩t	7 A CICITIT	AD DIC	TA CIT			Interval Between Onset and Death
1	/Medical Examiner		resulting in death)		(or as a conse		MINTON	ASCUL	MI DIS	EAOE			
	Examiner	- G	Sequentially list conditions, if any, leading to immediate	b	(or as a conse	quence of):							
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	6	(, , , , , , , , , , , , , , , , , , , ,							
,0	cate be executed physicien and the burial-transit	Exa	resulting in death) Last	Due to	(or as a conse	quence of):							
8760,	cate b physic the br	dical		d									
9		/Me	IF FEMALE:	23c. If yes, ou	tcome of pregn	nancy					23d D	ate of delive	254
Вох	death e atter d for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live t 4 ☐ Pregr	ointh 2 Fet nant at time of	aldeath 3□	Ectopic prec Other (spec					onth	Day Year
P.0	at the de by the a	hys	9 🗌 Unknown	9□ Unkn									
	The law requires that the death certifi tte has been signed by the attending tage 2 should be detached for use as	Ď	Part II. Other significent condition	s contributing to d	eath but not re	sulting in the ur	nderlying cau	use given in	Part I.		obacco use con Yes 2□No		he cause of death?
Ö	w requir been si should	etec											
Vital Records,	The law ate has page 2 s	Completed								24a. Was autop perfo	osy ormed?	prior to co death?	psy findings available mpletion of cause of
ta		0	25. Was case referred to medical					26	Place of Deat	1 ☐ Yes		1 🗌 Yes	2□ No
Ž	S D	To B	examiner? 1∭ Yes 2 □ No	Hospital:	Inpatient 2] ER/Outpatien	t 3 DOA	0				ner (Specif	AT SCENE
n of	ding Ph h. After th funeral		27. Manner of Death Natural 5 Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	280	c. injury at Work?			how injury occur		
sio	ne at e	catle	2 Accident investiga 3 Suicide 6 Could no	t he			М	1 🗆 Yes	2 No		_		
Division	after death after death Director:	Certification:	4 Homicide determin	ad 200. Flace	e of Injury - At h ing, etc. (Speci	nome, farm, stre ify)	eet, factory,	office		28f. Location (5 City or Tov		ber or Rura	il Route Number,
~	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical C	29a. Certifier (Check Only one) 1 Certifying X Medical Ex	Physicien: To the	asis of examin	owiedge, death	occurred at vestigation, in	t the time, da n my opinior	ate and place, n, death occur	and due to the red at the time,	cause(s) and m date and place,	anner as s	tated. o the cause(s)
	o the ithin 2 o the omple	Med	29b. Signature and Hitle of certifier	and man	ner stated.		29c.	License nun	nber		29d. Date signe	ed (Month.	Day, Year)
	H 3 H 8				1).C.M.			JULY	31,20	
	10		30. Name and address of person wi	no completed caus									
	ln		JACK	Notion	11.13/		N STRE	EET, B	ALTIMO	RE, MARYI	LAND 212	201	
	Sta ' Registr		31. Date filed Menn, Ray Year	J5 32. F	legistrar's Sign	ature	le le						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 0 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death July **Physician** June Ruth Hardina 6:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death **Examiner** Baltimore 7 Wood Oak Court Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Dec. 13, 1 5. Social Security Number 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖫 F Yrs. 218-12-3488 81 Director 1923 Maryland Usual Residence of Decedent 10b. County 10a State 10c, City, Town or Location 10d. Inside City Limits if Health and Mental Hygiene.
item 27 Is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Wood Oak Court 21236 u.s.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12th Grade Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John F. Ruth Wilson 9uinn Tarleton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Randolph Harding (husband) 7 Wood Oak Court. Baltimore. MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 8/1/2005 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions. onsequence of): Physician/Medical Examiner rany, loading to inmedit cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 1car 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 DNo
9 Unknown Month 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco, use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 Tyes 2 X No Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No No Vital 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only examiner? Hospital: 1 Inpatient 4 Nursing Home Certification; To 1 🗌 Yes 2 C ER/Outpatient 3□ DOA 50 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred Manger of Death 28b. Time of Division 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certific owner mo 50. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 UE

Registrar

State

31. Date filed (Month, Day, Year)

AUG 0 2 ZUUD

Harding

RUth

32. Registrar's Signature

V State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of per-

32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

M.D

Eleve It facile

OCME

July, 31, 2005

			1 - For State Registrar	State of Maryla	and / Dep	artment of H rtificate of I	lealth and M	lental Hygi	•		25112
			Decedent's Name (First, Middle, Last)				2. Date of Death Month	1		3. Time of Death
	Physici /Medio		Mantle	LaVerne Hood	d				31^{ay} , 20	Year 05	6:40p [™]
	Examir		4a. Fecility Name (If not institution, give				Location of Death		4c. County o		
			2816 Deerfield Dr 5. Social Security Number 6. Se		rs. last birthday)	If Under 1 Year	tt City If Under 24 Hrs.	9 Date of Birth		ward	and (State or Engine
	Funeral Director			M 2□F 8		Months Days	Hours Min.	8. Date of Birth (Month, Day, JUN 24,	1918	T111	ace (State or Foreign ry) Lnois
	yland		10a. State 10b. County	10c.	City, Town or Lo	ocation				10	d. Inside City Limits
	e Maried	ctor	Maryland Howard	1		Ellico	ott City				1 ☐ Yes 2 XNo
	or 28	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	nat Counti	ry?
	s 23e	eral	2816 Deerfield Dr	1Ve 12. Was Decedent Ever is	2116 12		21043	anifu Van ar Na	USA 14. Race	America	n Indian
396	72 hours after death with the Maryland Insturel, or Items 23a or 28a-f ehow deal Examanar out be motified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 \(\) Yes 2 \(\) No if Yes, Give Year or Dates:		Was Decedent of Holf Yes, specify Cuba 1 ☐ Yes 2X No	Specify:	Rican, etc.)		White, e	tc.
Maryland 21215-0036	72 hou	ted	15. Decedent's Edu (Specify only highest grad		16a. Dece	dent's Usual Occupa	ation	ina 1	6b. Kind of Bus	iness/Indu	ustry
21	E . E .	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of DO NOT use retired	()				
121	T		17. Father's Name (First, Middle, Last)	5+	Prof	essor	18. Mother's Name		Ethnomus		Logy
anc	be d la	Be	James Hood					a Mantle	aiden Sumame,) .	
Ž	ges 1 and 2 should be t of Health and Menta If item 27 Is marked or other treumatic ev	2	19a. Informant's Name/Relationship (7)	rpe, Print)	19b. Maili	ng Address (Street a			City or Town. S.	tate, Zip C	Code)
	1 and 2: Health ar tem 27 Is		Hazel Chung Hood/					Ellicott			
Je,	of Hea item		20a. Method of Disposition	201	b. Place of Dispo	Deerfield sition (Name of matory or other place	e)	Date 2	0c. Location - C	ity or Tow	vn, State
Ē	nit. Pages eartment of orient: If it injury or o		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	demoval from State		ematory,	· 1	./05	Baltimo	ore,	MD
Baltimore,	permit. Pages Department of I Importent: If ite any injury or of once.		21. Signature of Funeral Service Licens Dawn F.	mg mulo	2:	Cremation 299 Frede	s Society erick Road	of Mary	Land, In	nc.	228
	Pnysician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	tztel	ter the mode of dyin d - Jac				1	Approximate Interval Between Onset and Death
	Examiner			Due to (or as a cons	sequence ot):						
ч	EIVE	je.	if any leading to immediate	b. Due to (or as a cons	sequence of):						
W	be executed sician and burial-transit	Examiner		С.							
1760,	e exe		resulting in death) Last	Due to (or as a cons	sequence of);						
876	cate b	dical		d.							
.O. Box 68	ne death certificate be executed the attending physician and shed for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Monti		y Day Year
Δ.	The law requires that the de ste has been signed by the a page 2 should be detached to		Part II. Other significent conditions co	ntributing to death but not	resulting in the u	inderlying cause give	en in Part I.	23e. Did toba	acco use contrib	oute to the	cause of death?
ds,	uires signe	d by						1 ☐ Yes	2 346 3	☐ Probal	bly 4 □Unknown
Vital Record	w requir s been si should	ompleted						24a. Was an		ere autops	sy findings available
Re	The lav	ошь						autopsy perform	ed? de	or to comp ath? ⊒Yes 2	pletion of cause of
ita		se C	25. Was case referred to medical				26. Place of Death				
of V	S S	To B	examiner? 1 □ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3□ DOA Othe	er: 4 🗌 Nursing Ho	me 5 X Resider	nce 6 □ Other	(Specify)	
u o		on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time o	Work	c?	28d. Describe how	v injury occurred	t	
Sio	Attsnding r death. ector: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be	On Discontinuo	Ab (Yes 2□No	OOL Landing (Cts	and and Alumba	0	O
Division	for Attsnatter deat Director:	ertiflcation:	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	ecify)	reet, factory, office		28f. Location (Str. City or Town,		or Hurai i	Houle Number,
_	To the Hospital or within 24 hours after To the Funstel Dire ompletely filled in b	edical Co	29a. Certifier 12 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, deat lination and/or in	h occurred at the time evestigation, in my op	ne, date and place, pinion, death occurr	and due to the car ed at the time, da	use(s) and mann te and place, an	ner as stated	ted. the cause(s)
	othio omple	Me	29b. Signature and title of certifier			29c. License	number	29	d. Date signed (Month, Da	ay, Year)
}			1 Coult	M		P00 2	22432	2 1	3/1/00	5	
	20		30. Name and address of person who co	ompleted cause of death (I	Item 23a) (Type,	Print) woology	Univ	of MD	Hosp	21	20/
	Sta Registi	_	31. Date filed (Month, Day, Year) AUG 0 2 2	32. Registrar's Si	gnature #	Carles					

State of Maryland / Department of Health and Mental Hygiene For State Registrat Certificate of Death Reg. NO 115 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2005 Month **Physician** Beulah Agnes Hornsby Ju1y 28. 11:45 A M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 1451 Medfield Avenue N/A Baltliliole

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Days | Hours | Min. | Sept. 25, Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months 1□M 2XF Country) Virginia 92Yrs. Sept. 1912 Director 186-16-0011 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location ir than "natural", or Itams 23e or 28e-f show the Medical Examiner must be notified at MXYes 2 ☐ No N/A Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country 1451 Medfield Avenue **USA** 21211 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 230No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itan any injury or other traumatic syant, the Modical Exami 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: white ð XX Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assembler Martin Co. 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marshall Calloway Naomi Roberts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Naomi Cooley Daughter 1451 Medfield Avenue Baltimore, MD 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State Druid Ridge Cemetery 8/1/2005 Pikesville, Maryland ^¹ 4 □ Donation 5 Other (Specify) 22 Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland Aneral Service License 21. Signatura Baltimore, Maryland 21211 23a Part Ehter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failule. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 8 Vascular Dementiq /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) certificate be executed burial-transit Box 68760.⊄ and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the a Yes 2 No detached 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1□ Yes 2□No 1 Yes al or Attending Physician: after death. Director: After this certifice Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 21 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 1. Natural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide To the Hospital o within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 28/05 arlen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) h KICHURI Diamarl 2 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. N2 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Juty 31, 2005 **Physician** 4:15 A. Gladys Caspare Hagedorn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Hospital Belair Harford If Under 1 Year If Under 24 Hrs. Months Days Hours Min. May 9, 1908 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ XF Yrs. 217-03-3534 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a State 7 is marked other than "natural", or itema 23a or 28a-1 shor traumatic avent, the Medical Examiner must be notified at Marvland 1 ☐ Yes 2√ No Harford Fallston Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2308 Carlo Road 21047 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 № No Specify: Specify: USA 3XXWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewi fe Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Caspare Ella Mae Sommers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Travers/Daughter 2308 Carlo Road Fallston Maryland 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 □ Cremation 3 □ Removal from State
1 □ Donation 5 □ Other (Specify) Moreland Mem. Park 8/4/05 Baltimore Maryland 21. Signature of Funeral Service Licensee Christina L. Hilton 22. Name and Address of Facility Leonard J. Ruck, Ir 5305 Harford Road Thistma & He Baltimore Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Presmonia Physician Aspiration Z days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (ursease or indirect that the control of the control Due to (or as a consequence of): Examine Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes been si should Dementin 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 2 1 No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 npatient 1 Tyes 2 No this 28a. Date of Injury (Month, Day Year) After thi funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No I Director: A 2 Accident 6 ☐ Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year) AUG 0 2 2005

Kevin

Lynit no 2 North Ave. BelAir, Md. 21014

32. Registrar's Signature

5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

'agedon, Gladys

D35012

			For Stata Ragistrar		State of M	larylan		artmen rtificate				ental Hy	giene	0 0	5 2	251	16
	Physici /Medic		1. Decedent's Name		,	SR.						2. Date of De Month	Da Da	y ລະ	Year		of Death
	Examir		4a. Facility Name (/	-	ve street and number)				Location	of Death	<u>, , , , , , , , , , , , , , , , , , , </u>		. County o	-		
Ì.	Funeral Director		5. Social Security N 217-26-0	370	Sex 7. A 1☑M 2□F 74		ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di 0-26-19	rth ay, Year) 31		9. Birthpl Coun Mary	try)	e or Foreign
	Maryland f show ied al	lor	10a. State PA	10b. County Adams		1	, Town or Lo		_						10		City Limits
	with the Se or 28a-	Director	10e. Street and Nur 508 Lexi		√			10f. Zip					10g. Cit	izen of W	hat Coun	iry?	
036	within 72 hours after death with the Maryland ane. then "neturel", or Items 23c or 28a-f show ra Madical Examiner rual be notified at	by Funeral	11. Marital Status	ied 257 Married	12. Was Decedent Armed Forces 1 Tyes 2 T If Yes, Give Year or Dates:	? No	'	Was Deced	lent of Hi	spanic Ori n, Mexicar Specify:	n, Puerto F	cify Yes or No Rican, etc.)		14. Race Black	- America White, 6		
Baltimore, Maryland 21215-0036	filed within 72 ho Hygiene. sther then "netur ent, Ire Modical	Completed	(Spec	15. Decedent's E cify only highest g ondary (0-12)	ducation rade completed) College (1-4or	5+)	16a. Deced (Give life.	kind of wor DO NOT us	rk done a se retired	luring mos)				ind of Bus			
nd 2	lled lygi ther nt.	Be Co	17. Father's Name	(First, Middle, Las	t)		Darto		3011			(First, Middle		nspo: Sumame		on	
ryla	2 should be f and Mental b Is marked of aumetic eve	To	John Hof 19a. Informant's Na	ama/Palatianshin	(Tuna Print)		10h Mailir	Addross				Gather Route Numb	ne Cite	Tour 6	State 7in	Co do l	
Ma,	s 1 and 2 should f Health and Men item 27 Is marke other traumetic		Loretta I		(Type, Chil)		508 L	exing	ton	Way I	Littl	estown	PA	17340))	C006)	
imore	permit. Pages 1 and 2 Department of Health Importent: If item 27 I any injury or other tra once.				□Removal from State	C	lace of Dispo emetery, cren dar Hi	natory or of	ther place			ate 3 - 2005		ocation - 0 oklyr			
Balt	permit. Departr Importe any inji		21. Si vature of Fu	uneral Service Lio	Thurs	leck	22	Name and Pros 719 H	d Addres e Fu ammo	s of Facili neral nds I	Hom erry	e _R af L	ansd ansd	owne owne	MD 2	1227	
Į,			23a. Part . Enter to shock, or hea Immediate Cause		nplications that cause y one cause on each		V					r respiratory a	rrest,			Approxim Interval B Onset and	etween
	Pnysician /Medical		disease or condition resulting in death)		a. Perito			nga	ngre	nou	s g	allbio	rdd	ON	+1	rree	weeks
Ĭ	Examiner	ā	Sequentially list co	nditions,	b. — Duc to (or as	a eurasin	ranta di										
0,0	icate be executed physician and the burial-transit	Examiner	cause. Enter Under Cause (Disease or that initiated events resulting in death) I	5	c		·										
8760,	icate be physicia the bu	dical		•	d												
.O. Box 6	ne death certif the attending thed for use as	Physician/Me	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 [9 Unknown	months? □No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pre Other (spe						23d. Date Mont		ry Day	Year
0	res that igned b be deta	by	Part II. Othar signif	ficant conditions	contributing to death I	but not resu	ulting in the u	nderlying ca	ause give	n in Part I		23e. Did 1				e cause of	f death?
Vital Records,	The law ate has b page 2 sl	Completed										24a. Was auto perfo 1 Yes		pr de	ere autop ior to com ath? Yes	npletion of	s available cause of
Vita	Physicien: Tribis certificaral director, p	Be	25. Was case refer examiner?		Hospital:				Δ Othe	er.		(Check only					
on of	ing After une	tlon; To	1 ☐ Yes 2 ☐ 27. Manner of Deat 1 ☐ Natural 2 ☐ Accident		28a. Date of Injury		ER/Outpatien 28b. Time of Injury		Bc. Injury Work	at	2	ne 5 ☐ Resi 8d. Describe				<u> </u>	
Division	el or Attend safter death l Director: / d in by the f	Certification:	3 Suicide 4 Homicide	6 Could not determine	286. Place of in	jury - At ho tc. (Specify	me, farm, str	eet, factory	, office		2	8f. Location (City or To	Street an wn, State	d Numbei	r or Rural	Route Nu	mber,
	dospite 4 hours unerel ely fille	edical C	29a. Certifier (Check only one)	1 Certifying P 2 Medical Exa	hysician: To the best miner: On the basis of and manner s	of examinat	wledge, death	occurred a restigation,	at the tim in my op	e, date an inion, dea	d place, a th occurre	nd due to the d at the time,	cause(s)	and man I place, ar	ner as sta nd due to	ited. the cause	(s)
	To the twithin 24	Me	29b. Signature and	4	un M'D				License	number)			te signed		0ay, Year)	
	if		30. Name and addr	ess of person who	completed cause of UR 3001	death (Item	23a) (Type, H I+AR	Print)	257	- BAI	TIM	OREN	(AR)	YLAN	<i>D</i> a	3133	5
0.00	Sta Registr				39. Regist												
DI	MU 17 Day 170	104		£ 54 - 2	franchista de		1						-				

			State of Maryland / Den	artment of Health and Me	•	
			1 - State Registrar Ce	rtificate of Death	Reg.	2005 25117
	Physici	an	1. Decedent's Name (First, Middle, Last)	2	. Date of Death Month	Day 2005 3. Time of Death
	/Media	al	James Gordon Heath, Sr. 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	July 30	V. C. C.
	Examir	ier	Baltimore Washington Medical Center	Glen Burnie		4c. County of Death Anne Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		Date of Birth (Month, Day, Ye.	
	Director		228-03-1086	Months Davs Hours Min.	(Month, Day, Ye. 3-26-1917	ar) 9. Birthplace (State or Foreign Country) VA
	D >		Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or L			
	shoy	5	10a. State 10b. County 10c. City, Town or L MD Anne Arundel Glen Bur			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	289-1	ect	10e. Street and Number	10f. Zip Code	100	Citizen of What Country?
į.	within 72 nours atter death with the Maryland ene. 10. 11. Mar "naturat", or iteme 23a or 28e-f show the "mailed Examiner must be notified at the Maryled Examiner must be notified at the Maryled Examiner must be notified.	Completed by Funeral Director	406 Baylor Road	21061		S.A.
-	me 2;	nera		Was Decedent of Hispanic Origin? (Specif If Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No-	14. Race - American Indian,
ဖွ	or its	Ē	1 Never Married 2 Married Armed Forces? 1 XXYes 2 No 1945— If Yes, Size		can, etc.)	Black, White, etc.
21215-0036	ural',	d by	3XXWidowed 4 □ Divorced Year or Dates: 1946	1 ☐ Yes 2 ☐ No Specify:		Specify: White
5	"nati	ete	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation a kind of work done during most of working DO NOT use retired)	16b	. Kind of Business/Industry
12	than than	dmc	Elementary/Secondary (0-12) College (1-4or 5+)	cionary Engineer		Brewery
9	Hygi other ent, I		17. Father's Name (First, Middle, Last)	18. Mother's Name (F		<u> </u>
<u>a</u>	Menta Menta rked ric ev	To Be	Thomas Heath	Blanche E	Clliott	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Innportent: if them 27 is marked other than "natural; or iteme 29a or 28e-1 show any injury or other treumatic event, the Macheal Examinal must be notified at once.			ing Address (Street and Number or Rural F		
Σ ;	and sealth m 27 in ser tre		· ·	Baylor Road, Glen Bu		
Baltimore,	ges 1 tof H ffite or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State	osition (Name of Date matory or other place)		Location - City or Town, State
ţi.	then then tent: jury					ownsville, MD
Bal	Depar Impo any ir			2. Name and Address of Facility Sing Second Ave SW, Gle		
						Approximate
			23a. Part1. Energible disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	Bleeding	pa.c.y aoz.,	Interval Between Onset and Death
	nysician /Medical		Immediate Cause (Final disease or condition resulting in death) a. The Crahial Due to (or as a consequence of):	pleening		
E	xaminer					
	o .=	iner	Sequentially list conditions, if any, leading to immediate cause. Enter the addition of the cause of the conditions of the cause (Disease or Injury that initiated events c.			
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last			
760,	ate be executed nysician and he burial-transit	cai E	bue to (or as a consequence or).			
687	phys the		d			
) XO	ine raw requires that the death certificat ate has been signed by the attending phy bage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
Ď į	e atte	icia	in the past 12 months? 1	□Ectopic pregnancy □ Other (specify)		Month Day Year
Р.О	ned by the a	hys	9 Unknown			
S, I	igned be de	by F	Part II. Other significant conditions contributing to death but not resulting in the t	underlying cause given in Part I.		o use contribute to the cause of death?
Records,	been si should	Completed			1 🗌 Yes	2 No 3 ☐ Probably 4 ☐ Unknown
ec	has b	nple			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
al F	certificate ha				performed 1 ☐ Yes 2 🔽	death? No 1 Yes 2 No
Vital		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 Impatient 2 ☐ ER/Outpatient	26. Place of Death (C		
of		\vdash	27. Mann of Death 28a. Date of Injury 28b. Time of	of 28c. Injury at 28c	5 L Residence 1. Describe how in	6 ☐Other (Specify) jury occurred
ion	death. ctor: After th y the funeral	atio	1 Priatural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		
Division	after death Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28f.	Location (Street City or Town, Sta	and Number or Rural Route Number,
	rs after ei Dire	Cer	/			(4
9	voine nospire of steinuing within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical	29a. Certifier 1 Learning Physician: To the best of my knowledge, deal (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated	th occurred at the time, date and place, and ovestigation, in my opinion, death occurred	I due to the cause at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
4	within 2 To the comple	5 1	20h Signature and title of certifier	29c. License number	29d. [Date signed (Month, Day, Year)
) '	- ≩ ⊢ ŏ		Janes & With WITH	.D. 041365	Ju	nly 30, 2005
	/		30. Name and address of person who completed cause of death (Imam 23a) (Type.	Print)	7	O NO MINO
	り		30. Name and address of person who completed cause of death (Hem 23a) (Type. Solvate E. Wills A. 30) 31. Date filed (Month, Day, Year) 32 Registrar's Signature	Hospital Drive,	Glent	Surnit, [4, 2106]
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 2 2005	and, a		

			1 - For State Registrar	State of	Maryland		artment			and Me		giene		C .	25110	•
	_		Decedent's Name (First, Middle, L.)	ast)			imout	J 01 L	Journ		2. Date of Dea		200	J	3. Time of Death	_
	Physici		Cornelia			Heptin	istal'	1			Month \mathtt{July}	Day 27	200	ear	1:25 P M	
)	/Medio Examir		4a. Facility Name (If not institution, g	ive street and num					Location o	f Death	041)		County of I		1.23 1	_
			5130 Mountain F	Road			Pas	sadeı	na			A	nne A	rur	ide1	
	Funeral			Sex 7 1 ☐ M 2 ☐ F	'. Age (In yrs. la	• • • • • • • • • • • • • • • • • • • •	If Under Months	1 Year Days	If Under a	Min.	8. Date of Birtl (Month, Day	v, Year)	9.	Birthp	ace (State or Foreign try) D.C.	7
	Director		212-20-3686 Usual Residence of Decedent	- X	82	Yrs.					10-29-1	922			D.C.	_
	land		10a. State 10b. County		10c. City,	, Town or Lo	cation							1	Od. Inside City Limits	
	Mary Fig.	ठ्	MD ANNE A	RUNDEL	Pa	asaden	а								1 ☐ Yes 21 No	
	r 28s	Director	10e. Street and Number				10f. Zip	Code				10g. Citi:	zen of Wha	t Coun	try?	_
	23a c		5130 Mountain	Road				211	22				USA			
	r dea	Funeral	11. Marital Status	12. Was Deced	lent Ever in U.S	i. 13. V	Vas Deced f Yes, spec	ent of His	spanic Orig	in? (Spec	cify Yes or No-	. 1	I 4. Race - A			
36	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 If Yes, Give)	1	I □ Yes 2		Specity:		,,		Specify:			
Ş	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23s or 28s-f show he Medical Examinat nual be notified at	d be	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dat	les:	16a. Deced	loot's Hous	I Ossuns	tion				nd of Busin			_
15	n n	Completed	(Specify only highest g	rade completed)		(Give	kind of wor DO NOT us	k done di	urina most	of working	9				lustry	
212	d with giene	E	Elementary/Secondary (0-12)	College (1-4 5+	4or 5+)	Pri	ncipa	1				Ec	lucat	Lon		
b	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Ie marked other than "natural", or Iteme 23a or 28a-f ehow tarmed the restless or 18a-f ehow tarmed the restlined at aumatic event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Las	it)					18. Mothe	r's Name	(First, Middle,	Maiden .	Sumame)			
<u>yla</u>	Ment Ment Mrked arked	10	J.Moler Ande	rson						Grace	e Carri	ck A	nders	son		
Baltimore, Maryland 21215-0036	2 she and lead		19a. Informant's Name/Relationship		Till till						Route Numbe	_			Code)	
<u>ح</u>	l and lealth im 27 her ti		Mr. Marvin Heptin	nstall/sp							adena,					_
ŏ	iges if it or of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3			ace of Dispo metery, cren				8/1/2	2005		cation - City Kridge			
ᄩ	it. Partituer ritant nijury		4 Donation 5 Other (Spec		Mead	lowrid	_		ry							_
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 is marked any Injury or other traumatic as ODCs.		21. Signature of Funeral Service Lice	llas	M01364	1		ıd Av	re SW	Glen	gleton Burni	e MD	ral F 2106	lome 1	P.A.	
			23a. Part1. Enter the disease, or con shock, or heart failure. List on	mplications that car y one cause on ear	used the death. ch line.	Do not ente	er the mode	of dying	, such as	cardiac or	respiratory arr	rest,			Approximate Interval Between	
)	Physician		Immediate Cause (Final disease or condition resulting in death)		ug osti.		-(a	1 6	a.lu	- 8					Onset and Death	
1	/Medical Examiner		resulting in dealiny	Due to (o	r as a conseque	ence of):										
		9	Sequentially list conditions,	b. Due to (or	r as a conseque	ence of:			-							_
B	uted d ansit	Examiner	if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	=												
, ,	be executed sicien and burial-transit		resulting in death) Last	Due to (or	r as a conseque	ence of):										_
8760,	Attending Physician: The law requires that the death certificate be executed to death. Todath. scrot. After this certificate has been signed by the ettending physician and by the funeral director, pege 2 should be detached for use as the burial-transit	dicai		d.										4		
9	antifica ing pt	Med	IF FEMALE:										-	-		-
Вох	ath co	lan/	23b. Was decedent pregnant in the past 12 months?		th 2 ☐ Fetal o	death 3	Ectopic pre					2	3d. Date of Month		y Day Year	
o.	the de	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4∐Pregnai 9□ Unknow	nt at time of dea vn	ath 5	Other (spe	ecify)				İ	***************************************			
σ.	that the the the the the the the the the th	Completed by Physician/Me	Part II. Other significant conditions	contributing to dea	th but not result	ting in the un	derlying ca	use give	n in Part I.		23e. Did to	bacco us	se contribut	te to th	a cause of death?	_
ds	puires	d b	Rost, utive	Lung	41100						1 🗆 Yı	es 2[]No 3[] Proba	ably 4 Sunknown	
8	s bee	lete	CAD								24a. Was a	an	24b. Wer	autor	sy findings available	-
æ	The It	E O									autops	med?	prior deat	to con	pletion of cause of	
ţ	lan: rtifice tor, p	0	25. Was case referred to medical						26. Place	of Death /	Check only on	2 X No	10	Yes	2 No	. –
>	nis ce direc	To B	examiner? 1 ☐ Yes 2 Do	Hospital: 1 Inp	patient 2 E	R/Outpatient	3 □ DO	Othor			e 5 X Reside		Other (Specify		
0	fter th	ä	27. Manner of Death 1 Natural 5 Pending	28a. Date of (Month,	Injury 2 Day Year)	28b. Time of Injury	28	Bc. Injury Work			d. Describe h		· · · · · · · · · · · · · · · · · · ·			-
Sio	eath. or: A	cati	2 Accident investigation 3 Suicide 6 Could not				М	1 🗆 Y	es 2 🗆 N	lo						
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death, within 24 hours after death. To the Funeral Director: After this certificete has been signed by the ettending completely filled in by the funeral director, pege 2 should be detached for use as	Certification:	4 Homicide determined	4 286. Place 0	f Injury - At hom g, etc. (Specify)	ne, farm, stre	et, factory,	office		28	Bf. Location (Si City or Town		Number o	r Rural	Route Number,	
_	spita nours neral / filled	aC	29a. Certifier 1 Certifying P	hysician: To the b	est of my know	ledge, death	occurred a	it the time	e, date and	place, an	nd due to the c	ause(s)	and manne	r as sta	ated.	_
	n 24 I	edical	(Check only 2 Medical Exa	miner: On the bas and manne	is of examination	on and/or inv	estigation,	in my opi	nion, death	n occurred	d at the time, d	late and	place, and	due to	the cause(s)	
	Vithi Comp	ž	29b. Signature and title of certifier				29c.	License	number		2	9d. Date	signed (M	onth, E	Pay, Year)	_
	, .		Marie a	Stu) NO		1	132	-5-4	3		7	128/	05		
	18		30. Name and address of person who				Print)	4				15-	1.			
	\			10 Mysens		6701		, , ,	Chou	-101	+2	De	1+	~		_
	Sta Registr		31. Date filed (Month, Day, Year)	32. Heg	gistrar's Signatu	Level										
	3		AUG 0 2 2005	ALLEY S.	1 10 1	7										

			1 - For State Registrar	ate of Maryland		artment of H			2005	25119
	Physici	an.	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		Dora E. Huddleston						2005	10:30 A ^M
7	Examir	ner	4a. Facility Name (If not institution, give street			**	Location of Death	1	4c. County of Death	
	Francis		719 Maiden Choice La 5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthdav)	Catons	V111e If Under 24 Hrs.	8. Date of Birth	Baltimo	Ore place (State or Foreign
п	Funeral Director		217-03-2851 ^{1□ M}		Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye Aug. 28,	1919 Mary	ntrv)
	D .		Usual Residence of Decedent 10a. State 10b. County	100 000 1	r					
	anyla ehov	jo	10a. State 10b. County Maryland Baltimore	10c. City, 1		ville				10d. Inside City Limits
	28a-f	ect	10e. Street and Number		acons	10f. Zip Code		100	Citizen of What Cou	
	3a or	Funeral Director	719 Maiden Choice La	ne HR 546		2122	R		USA	ind y r
	death ms 2	nera	11. Marital Status 12. W	as Decedent Ever in U.S.	13. V	Vas Decedent of Hi f Yes, specify Cuba			14. Race - Americ	
98	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23e or 28e-f ehow event, the Medical Exerting must be notified at	/Fui	1 ☐ Never Married 2 Married 1	rmed Forces? □ Yes 2 XNo Yes, Give	1	r Yes, specify Cuba □ Yes 2 🛛 No		o Rican, etc.)	Black, White, Specify: Wh	
21215-0036	hours ural',	d by	3 Widowed 4 Divorced Y	ear or Dates:						nite
15-	in 72	Completed	15. Decedent's Education (Specify only highest grade con	pleted)	16a. Deced (Give life. L	lent's Usual Occupa kind of work done o DO NOT use retired	ition during most of wor)	king 16b	. Kind of Business/In	dustry
212	filed with Hygiene. ther than	Шо	Elementary/Secondary (0-12) C	0 ollege (1-4or 5+)	Homen		,		Own Home	
b	should be filed within ad Mental Hygiene. marked other than imatic event, in a Mi	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, Maid		
Maryland	2 should be f and Mental h Is marked of reumatic eve	To E	Frederick Rosenthal				Dora E.			
Mar	2 8 8		19a. Informant's Name/Relationship (Type, F					ral Route Number, Ci		
	t and tealth om 27		David W. Huddleston 20a. Method of Disposition	-		laiden Cho sition <i>(Name of</i>	oice Lane	Pate 200		
סב			1 🔀 Burial 2 □ Cremation 3 □ Remov	al from State	etery, cren	natory`or other place			. Location - City or To	
Baltimore,	# せせっ .		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Sharatur of Funeral Service Licensee	Loud		rk Cemete		/2005 Bard Fund	altimore,	
Ba	permi Depa Impo any ir		Wilhard OS	chin	41	07 Wilker	ns Avenue	, Baltimo	eral Home, re, Maryla	ind 21229
	Physician /Medical		23a. Part1. Embr the disease, or complicatio shock, or heart failure. List only one ca immediate Cause (Final disease or condition resulting in death)	ns that caused the death. I use on each line. Due to (or as a consequer	Va			or respiratory arrest,	<i>t</i>	Approximate Interval Between Onset and Death
	Examiner	<u></u>	Sequentially list conditions, b.	Due to for as a consequen	an of					
	ted nsit	Examine	Sequentially list conditions, b. — cause. Enter Underlying Cause (Disease or injury	The to for as a consequen	CH THE					
×	ate be executed hysician and the burial-transit	Exar	that initiated events c. resulting in death) Last	Due to (or as a consequen	ice of):					
8760,	cate be ohysicia the bur	cai	d.							
9	ntifica ng ph as th	Jedi	IE ECHALE.							
.O. Box	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	Physician/Medi	in the past 12 months?	yes, outcome of pregnancy □Live birth 2 □ Fetal de □ Pregnant at time of deatl □ Unknown	ath 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
Vital Records, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions contribu	ing to death but not resultin	ng in the un	derlying cause give	in in Part I.	23e. Did tobacc	co use contribute to the	ne cause of death?
Sec	e law r has be	ompieted						24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
alF		O						performed		2 No
Σ	15. Se	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospit	al: 1 ☐ Inpatient 2 ☐ ER	(O. A. A.	Othe	Ar.	th (Check only one)		
ō		\vdash	27. Manner of Death 28	a. Date of Injury 28	b. Time of	28c. Injury Work	4 Nursing H	28d. Describe how in	6 □Other (Specifinitury occurred	у)
ion	토 중 글	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		? ′es 2 □ No			
Division	or Attendente of the control of the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28	e. Place of Injury - At home building, etc. (Specify)	, farm, stre	eet, factory, office		28f. Location (Street City or Town, St	and Number or Rura	I Route Number,
	Itel or A	Cer								
	To the Hospitel or Al within 24 hours after o To the Funerel Direc completely filled in by	edical	(Check only 2 Medical Examinar: (: To the best of my knowle on the basis of examination and manner stated.	dge, death and/or inv	occurred at the tim estigation, in my op	e, date and place, inion, death occur	and due to the cause red at the time, date	e(s) and manner as si and place, and due to	tated. the cause(s)
\	To the within 2. To the complete	Me	29b. Signature and title of certifier	Mea	100	29c. License			Date signed (Month,	
,	1		30. Name and address of person who complete	d cau death (Item 33	la) (Type 1	Print)	1025	6	, 000	
S-2	V	, u	A. SHAMS PIRZAD	EH, NO, 7	16 M	AIDEN	CHOICE	Lane	Red Teme	91798
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature)					0166
DH	Registr MH 17 Rev 1/20		AUG 0 2 2005	32. Registrar's Signature	4 4	parke				

ORIGINAL

			1- State of Maryland / Department of Heading State of Maryland / Department of Heading State of Department of Heading State of Maryland / Department / Depar		, ,	iene	15	25120
	Physici		1. Decedent's Name (First, Middle, Last) Richard Joy		2. Date of Death	Day	Year 2035	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Lo	ocation of Death	9019	4c. County		0 00 1
			St. Agnes Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year II	e If Under 24 Hrs.	9. Date of Birth		0 Right	place (State of Forming
	Funeral Director			Hours Min.	8. Date of Birth (Month, Day, Oct. 9,	^{Year)} 1950	Mar	place (State or Foreign oftry) y Land
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				1	0d. Inside City Limits
	Manyla -f sho	ţō	MD Baltimore Catonsville					1 ☐ Yes 2 ☑ No
	h the or 286 s rotii	Funerai Director	10e. Street and Number Catcolls VIIIe 10f. Zip Code		10	Og. Citizen of	What Cour	ntry?
	23a c	rai D	2210 Pleasant View Ave. 21228			USA		
	er des Items	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispi If Yes, specify Cuban, I	anic Origin? (Spe Mexican, Puerto F	cify Yes or No- Rican, etc.)		ce - Americ	
326	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygene. Important: if item 27 is marked other than "netural" or Items 23a or 28e-1 show appringny or other traumatic event. It a Medical Examinat must be notified at ance.	by F	1 ☐ Never Married 2 Married 1 ☐ Yes 2 M No 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	Specify:		Specif	y: Whi	te
5	72 hou	eted	15. Decedent's Education 16a. Decedent's Usual Occupatio (Give kind of work done duri	on ring most of workin	100	6b. Kind of B	usiness/ind	dustry
101	within ne.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	ing most or working	,9	T /0	1.0	1 1
ن ح	filed v Hygie other t		4+ Lawyer 17. Father's Name (First, Middle, Last) 18	8. Mother's Name	(First, Middle, M			mployed
Manyland 21215_0036	uld be Mental rked of tic ev	To Be	Thomas Edward Joy	/irginia	Abrecht			
2	2 short and half small small small suma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and	d Number or Rurai	Route Number,	City or Town,	State, Zip	Code)
2	C, IV		Mary Kidd/Wife 2210 Pleasent 20a. Method of Disposition (Name of			sville		
Š	ages of the first		M¥Burial 2 ☐ Cremation 3 ☐ Removal from State	8-3-2		Cibert	,	
ezemi+leg	nit. Partme vartme orteni injury		21. Signature of Epiperal Service Licenses 22. Name and Address of	of Facility				
à	Dermi Depai Impo		Sterling A 736 Edmond	shton Sc	hwab Fu	neral H	Home,	Inc.
	*		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, s shock, or heart failure. List only one cause on each line.	such as cardiac or	r respiratory arre	st,	111 21.	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) a					Onset and Death
	/Medical Examiner		Due to (or as a consequence of):					
	E. WENG	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of injury					
D	cate be executed only sician and the burial-transit	Examiner	that initiated events C.					
, 0928	be exe		Due to (or as a consequence of):					
687	fficate g phys	edic	d					
Rox 6	The control of the death certification is a second of the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the part 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy			23d. Da	te of delive	ry
<u> </u>	the att	/sicia	in the past 12 months? 1			Mo	nth	Day Year
٥	that the de ed by the detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	in Part I.	23e. Did toba	acco use cont	ribute to th	e cause of death?
t o	w requires that been signed to should be deta	ed by	Idiopathic cardiomyopathy		1 🗆 Yes	s 2 □ No	3 Prob	abiy 4 Onknown
7	e law rec has bee	ompleted			24a. Was an	24b.	Were autor	osy findings available
M =		Com			autopsy perform 1 Yes 2	ed2	death?	npletion of cause of 2 No
₹ × ×	Physician: The this certificate ral director, pag	Be	examiner?	6. Place of Death				
27 5	5 E B	- To	1 Inpatient 2 E-EH/Outpatient 3 DOA	4 Nursing Hom	ne 5 Resider 8d. Describe hov)
	nding Ph ath. r: After th e funeral	ation	1 Natural 5 Pending (Month, Day Year) Injury Work?	s 2 No	2. 20001.00 1101	v injury coour		
icho Division	r Atte r Atte ler der recto	ertification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify)	2	8f. Location (Stre		er or Rura	Route Number,
5	urs aff	O						
,	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edicai	29a. Certifier (Check only one) 1 ★ Certifying Physicien: To the best of my knowledge, death occurred at the time, or and annew fate of the basis of examination and/or investigation, in my opinion and manney fate of the control of the basis of examination and/or investigation, in my opinion and manney fate of the control of the basis of examination and/or investigation.	date and place, ar ion, death occurre	nd due to the cat d at the time, dat	use(s) and ma te and place,	inner as stand due to	ated. the cause(s)
	To the To the To the Compl	Me	29b. Signature and attle of certifier 29c. License nu			d. Date signe		
	/		mo Doc	7733	12 -	July	29	2005
	5	1-22	Michelle Henggeler, 900 Caton Avenue	, Bal.	timore,	MD	212	29
	Sta Registr		AUG 0 2 2005					

05-04 Josep	4988 oh O. ()1w	gbenga Amend ite	ase Type or Pri m/5, perFH, G State of N	At in Flack laryland / Der	nd elible ink partment of l	. Ensure All Health and M	I Copies Iental Hy	Are L	egible.	
RJD —			Registrar		Ce	ertificate of	Death		Reg. No.	005	25 2
	Physici /Medi		Decedent's Name (First, Middle OLUGBENGA)	dle, Last) JOSE	PH			2. Date of De Month July		005 Year	3. Time of Death 2155P. M
	Examir		4a. Facility Name (If not institution			4b. City, Town,	or Location of Death		4c. C	ounty of Death	1
3.5 194 a		3	Route 450 and		vard ge (In yrs. last birthda)	Lanham If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	Pr	ince Go	Porges
	Funeral Director		5. Sacial Security Number 0 216-57-1480 Usual Residence of Decedent	4 X 14 0 C C	31 Yrs.	Months Days		July 6	^y 1974	Nig	intry! eria
	yland now		10a. State 10b. Count	у	10c. City, Town or I	Location					10d. Inside City Limits
	Mar 6-1-at	ctor	MD Princ	ce George's	Bowie						1 XYes 2 No
	vith the	Funeral Director	10e. Street and Number			10f. Zip Code	0721			n of What Cor	
	s 23s	era	14907 Dahlia	12. Was Deceden	t Ever in II S		Hispanic Origin? (Spe	noty Voc or No		S, Nige	
21215-0036	ges 1 and 2 should be illed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If of Health and Mental Hygiene. If it is a 73 is marked other than "natural", or items 23a or 28e-f ahow or other traumatic avant, the Medical Exart ar must be notified at	by Fun	11. Marital Status 1 □ Never Married 2 ☑ Ma 3 □ Widowed 4 □ Divorce	Armed Forces rried 1 □ Yes 2 □	?]No	If Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	-	Black, White	
2-0	72 ho	ted		int's Education est grade completed)	16a. Dec	edent's Usual Occu	pation during most of work	ung.	16b. Kind	of Business/I	ndustry
21	ithin Jan 1	Completed by	Elementary/Secondary (0-12)	College (1-4or	5+) life.	DO NOT use retire	ed)	9	D.,,		
2	iled w Hygier ther ti		12th 17. Father's Name (First, Middle	/act)	Com	puter Ana	18. Mother's Name	First Middle		ivate	
Maryland	Mental Mental Markad of	To Be		eph			01asumb			amame)	
Man	2 sho	i l	19a. Informant's Name/Relation			-	t and Number or Rura		-		ip Code)
45	is 1 and 2 of Health of item 27 is other tra		Dr. Timothy Ag	beja/Father	20b. Place of Disp			am,Mary Date		Ltion - City or 1	Town State
Baltimore,	permit. Pages 1 Depertment of H importent: If ites any injury or ott		1 XBurial 2 ☐ Cremation		cometery, cr	ematory or other pla	etery 8/4			ton,Mai	
튶	ertme ertme ortent injury		4 Donation 5 Other (1		22. Name and Addre					al Home
Ba	Deperminant in policy in p		1	13			lover Road				
	Physician /Medical Examiner		23a. Part1. Enter the disease, shock, or heart failure. Li- lmmediate Cause (Final disease or condition resulting in death)	- TED	ed the death. Do not e line. Do not e line. s a consequence of):	nter the mode of dyi					Approximate Interval Between Onset and Death
	\$ 3.	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or a	s a consequence of):						
	e be executed sicien and surial-transit	sai Examiner	that initiated events resulting in death) Last	cDue to (or as	s a consequence of):						
687	tificati ig phy as the	ledic									
D. Box	To the Hospital or Attending Physician: The law requires that the death certificate, within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physis completely filled in by the funeral director, page 2 should be detached for use as the t	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	☐Ectopic pregnand ☐ Other (specify) _	y		230	d. Date of deline Month	very Day Year
P.O.	that the di ed by the detached		Part II. Other significant condit	tions contributing to death	but not resulting in the	underlying cause gr	ven in Part I.	23e. Did t	obacco use	contribute to	the cause of death?
ords,	v requires been signi should be	ed by						10	1.7	/	bably 4 Unknown
Division of Vital Records,	The law recate has be page 2 sh	Completed						24a. Was autor perfo 1 Pes	rmed?	24b. Were aut prior to c deatb? 1 🔲 Yes	topsy findings available ompletion of cause of 2 No
Vita	ysician: is certific director,	Be	25. Was case referred to medic examiner?	al Hospital:		100	26. Place of Death	Check only o	ne)		
ot	Physic this c	٠ <u>۲</u>	1 x Yes 2 No 27. Manner of Death	1 ☐ Inpat		BIIL 3 DOA	her: 4 Nursing Ho	me 5 Resident		Other (Spec	
ou	ding Ph th. After th tuneral	tion	1 □Nyatural 5 □ Pend		ay Year) Injury	√ Wo	ork?				FUMMEN Q.
Divisi	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could	28e. Place of Ir building, e	njury - At home, farm, s			28f. Location (S City or Tov	Street and I vn, State)	Number or Ru	ral Route Number,
	ospita hours inerei		29a. Certifier 1 ☐ Certify	ing Physician: To the bes	t of my knowledge, dea	ath occurred at the ti	me, date and place,	and due to the	cause(s) ar	nd manner as	stated.
	the H in 24 the Fi	ledical	one)	il Examiner: On the basis and manner s	or examination and/or stated.						
	To To	Σ	29b. Signature and title of certif	The Skull	wo		se number CME		29d. Date s Jul	signed (Month y 24,	. <i>Day, Year)</i> 2005
	5		30. Name and address of perso	n who completed cause of	death (Item 23a) (Type	^{9, Print)} 111 P	enn Street	t Balt:	imore	, Mary]	land 21201
· (2)	Sta Registi		31. Date filed (Month, Day, Yea		trar's Signature						

DHMH 17 Rev 1/2001

ORIGINA

			For Stete Registrer	State of Marylan		artment of F		nd Mental Hy	rgiene Reg. N2 0 0 5	5 25122
	Physici		1. Decedent's Name (First, Middle, Last) Wayne	М.	Johns	ston		2. Date of De Month July		3. Time of Death 9:57 P M
	/Medio Examir		4a. Fecility Name (If not institution, give str 1105 Hotel Drive	reet and number)		4b. City, Town, o		Death	4c. County of D	Arundel
	Funeral Director		5. Social Security Number 6. Sex 215-34-8495 Usual Residence of Decedent	7. Age (In yrs. 66	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of Bi		Birthplace (State or Foreign Country) Maryland
	Maryland -f show	tor	10a. State 10b. County Maryland Anne Arun		y, Town or Lo adena	cation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with the 23a or 28e st be roti	al Director	10e. Street and Number 1105 Hotel Drive	dei Tub.		10f. Zip Code	122		10g. Citizen of What	•
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked othar then "netural", or items 23s or 28e-1 show other traumatic event. If a Medical Exertiner nast be notified at	y Funeral	1 Never Married 2 Married	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	1	Was Decedent of H	ispanic Origin n, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)		American Indian, Vhite, etc.
Maryland 21215-0036	in 72 hours n "netural" 'edicul Ex	Completed by	3 Widowed 4 Divorced 15. Decedent's Educa (Specify only highest grade	completed)	(Give	lent's Usual Occup kind of work done DO NOT use retired	durina most o	f working	16b. Kind of Busine	White
nd 212	be filed with tal Hygiene. id othar the	Be Com	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4or 5+) N/A		chasing A	18. Mother's	Name (First, Middle	, Maiden Sumame)	Supply Compan
laryla	2 should be and Mental Is markad o	To	19a. Informant's Name/Relationship (Type	a, Print)				or Rural Route Numb	er, City or Town, Stat	
	Pages 1 and 2 nent of Health a int: If item 27 I iry or other tra	197	Angela R. Johnston 20a. Method of Disposition 1 Burial 2 Cremation 3 Rea	20b. P	_ lace of Dispo emetery, cren	sition (Name of natory or other place	e)	Date	aryland 21	or Town, State
Baltimore,	permit. Pages Department of Important: If i any injury or once.		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral Service Licensee			1 Cemeter		4/05 Funeral	Brooklyn Home, P.A. na, Maryla	
68760, éa	Cate be executed //Medical Examiner in the burial-transit	dical Examiner	23a. Page. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequence to (or as a consequence)	uence of):					Approximate Interval Batween Onset and Death
O. Box	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetat 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
₾.	sign d be	by	Part II. Other significant conditions control DIABETES	ibuting to death but not resu			en in Part I.			e to the cause of death? Probably 4 □Unknown
Vital Records,		Completed						24a. Was autoj perfo 1 🗆 Yes	psy prior death	autopsy findings available to completion of cause of 1?
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	spital:		Out		Death (Check only o		
of	ding Phys h. After this funeral dii	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl	at	28d. Describe	dence 6 Other (S	pecify)
Division	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (: City or Tox	Street and Number or wn, State)	Rural Route Number,
	To the Hospitel or A within 24 hours after To the Funerel Dire completely filled in b	edical	one)	cien: To the best of my known: On the basis of examinat and manner stated.	wledge, death tion and/or inv	estigation, in my op	oinion, death	occurred at the time,	date and place, and o	due to the cause(s)
	To To	Σ	29b. Signature and title of certifier	1111		29c. License			29d. Date signed (Mo	The second secon
	3		30. Name and address of person who com	pleted cause of death (Item	23a) (Type, I	Print) 710 Utu	RCH	ST. BA	TIMME	, MD21225
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 2 20	32. Registrar's Signat	ture	parts				

			for State	State of Marylar	nd / Department of Health a	and Me	3 0.	~ ~ ~ ~	05100
			Registrar 1. Decedent's Name (First, Middle, Lasi	9)	Certificate of Death	1 2	Reg.	2005	25123
	Physici	an	Decedent's Name (Pirst, Middle, Las		NNEOY	2	Month	Day Year	3. Time of Death
100	/Medic Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of	of Death	Toly?	4c. County of Dea	
*	Lxamin		Harrol H	OSITAL	BALTI	MOR	E	NIA	
	. Funeral		Social Security Number 6. S		Months Days Hours	24 Hrs. 8 Min.	Date of Birth (Month, Day, Ye	9. Bir	thplace (State or Foreign
	Director		Usual Residence of Decedent	66	Yrs.	F		939 \$.	CAROLINA
	land ow		10a. State 10b. County	10c. Ci	ty, Town or Location				10d. Inside City Limits
	Man a-f sh	tor	N. Y.	N	EW YORK City				1 ☐ Tes 2 ☐ No
	th the	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	ountry?
	death with the Maryland ms 23s or 28a-f show	ral	100 WEST 11495	TREET	10026			U.SA	
	er de	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No	I.S. 13. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican	gin? (Specif i, Puerto Ric	fy Yes or No- can, etc.)	14. Race - Ame Black, Whi	
336	be filed within 72 hours after death with the Marylan Ital Hygiene. In other then "neturel", or Itams 23s or 28a-f show event, I've Marical Extraction of the calified at	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:			Specify:	Ack
2-0036	72 hou	Completed	15. Decedent's Edi (Specify only highest grad	ication	16a. Decedent's Usual Occupation (Give kind of work done during most	t of working	16b	. Kind of Business	/Industry
2	within 72 ene. than ne	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)	A a 1) ,	HOTEL
22	filed w Hygier othar ti		17. Father's Name (First, Middle, Last)		I HOUSEKEEPING 1	MANA	First Middle, Maid	OGER U	111, Am5
land	fental l fental l rked o	To Be	KAISIO	ALGOO	1/0	i s (vains)	0,	7	
Mary	2 should be and Menta is marked sumatic ev	F	19a. Informant's Name/Relationship (T	/pe, Print)	19b. Mailing Address (Street and Number	or or Rural F		or Town, State,	Zip Code)
	25 End	E	UGENE KEN	NEdy	100 WEST 114 5	st. /	15W7	ORK n	4 10026
altimore,	of Hea of Hea if item or othe	- 1	20a. Method of Disposition 1 Burial 2 Cremation 3		Place of Disposition (Name of cemetery, crematory or other place)	Dat	e 20c	. Location City or	J wn, State
Ē	permit. Pages Department of Importent; If it any injury or o		*4 □ Donation 5 □ Other (Specify,	50	inset GARDENS Mem	8/7/	2005F	LOREN	D. C.D.
Bai	permit. Pages Department of Importent: If ii any injury or o		21. Signature of Funeral Service Licens		AR SA Address of Facility	Jone	5, 78.	j-unera	LIDERVICE
	110 4 6		23a. Fart1. Enter the disease, or comp	lications that the sed the dear	th. Do not enter the mode of dying, such as		M / A1	HMORE	Approximate
	Physician	ļ į	shock, or heart failure. List only of Immediate Cause (Final	ne cause on the line.	3765++4		200 100		fnterval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as a conseq	quence of):				royeas
	Examiner		Sequentially list conditions,	bH	YPERTENSION				20 years
l.	Sit 3d	iner	r any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	` ´				
(be executed sician and burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseq	LART DISE	+ SE	-		Lo Yeus
8/60	sician buria	dicalE		d	(
9	tificate ig physi as the l	au i		J					
X Q	at the death certific by the attending p stached for use as	Physician/M	23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta				23d. Date of de	,
O.	ie dea the at hed fo	/sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of d 9☐ Unknown	death 5 Other (specify)			Month	Day Year
ב	The law requires that the steep seem signed by the sage 2 should be detached.			ntributing to death but not res	sulting in the underlying cause given in Part I.		23e. Did tobacc	co use contribute lo	the cause of death?
Vital Hecords,	uires sign	d by		Ÿ	,,,,		1 🗆 Yes	2 No 3 P	obably 4 Munknown
O O	w requires si should I	Completed					24a. Was an	24b. Were au	Itopsy findings available
H	sicien: The law certificate has b irector, page 2 s	шо					autopsy performed 1 ☐ Yes 2 Ø	2 death?	completion of cause of
<u> </u>		ВеС	25. Was case referred to medical examples?		26. Place	of Death (C	Check only one)		
010	y sin	10	1 DXYes 2 □ No					6 ☐ Other (Spe	cify)
	ling F	lon:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ N	i	d. Describe how in	njury occurred	
DIVISION	death death ctor: y the	licat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h			Location (Street	t and Number or Ri	ural Route Number,
\leq	al or /	Certification:	4 Homicide	building, etc. (Specif	ome, farm, street, factory, office fy)		City or Town, St	tate)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funera		29a. Certifier 1 Certifying Phy	sician: To the best of my kno	owledge, death occurred at the time, date and attended and and/or investigation, in my opinion, deat	d place, and	due to the cause	e(s) and manner as	stated.
	the H the F the F	Aedical	one)	and manner stated.		n occurred			
	To To	Σ	29b. Signature and attle of certifier	M D	29c. License number			Date signed (Mont	
•	1		20 Name and address of	ompleted cause of death (to-	Dodo 17-	7	Ju	14 31,	1005
	9		30. Name and address of person who c $Ro_{\lambda} F/FFN$	BEIN, M ,		A Alord	ER St	BAIL	MOPE IN
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature	7//00	-11 /11	PITCT I	2/225
	Registr	ar	AUG 0 2 200:	32 Registrar's Signa	* South				

	а	nend item#19b,23e	perFH, Md, G84	6.8/2/05	nent of Hea	alth and M	ental Hygier	e Legible. ne	
		For State Registrar	State of Marylar		cate of De		Reg.		25/21
		Decedent's Name (First, Middle, La	st)	0			2. Date of Death	Day Year	3. Time of Death
Physic /Medi		Barbara	KIN	6			July.	30 200	5 0246M
Exami		4a. Facility Name (If not institution, giv	0 1/	4b.	City, Town, or Le	ocation of Death		4c. County of Deatl	ard
Furnancia		5. Social Security Number 6. S	ex 7. Age (In yrs.			f Under 24 Hrs.	8. Date of Birth	9. Birth	pplace (State or Foreign
Funeral Director			□M 2 DF	Yrs. Mc	onths Days I	Hours Min.	8. Date of Birth Month, Day, Ye.	933 A	abama
and *		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ity, Town or Location	n		,.		10d, Inside City Limits
Maryla f sho	ğ	mo Har-	Ford 1	301 Air					1 ☐ Yes 2 No
ith the Marylar or 28a-f show	rec	10e. Street and Number	0.0	1	Of. Zip Code	[10g.	Citizen of What Co	untry?
d 21215-0036 filed with the Maryland Hige within 72 hours after death with the Maryland Hygiene. There then "neturel", or femis 23s or 28s-f show ont, the Medical Examinar must be notified at	Funeral Director	300 SUNHOW	er Dr. #3	H8	210	14		USH	1. 1.
er des	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 D No	J.S. 13. Was	Decedent of Hisp s, specify Cuban,	anic Origin? (Spe Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Arne Black, White	
036 urs aft	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	10	Yes 2. No :	Specify:		Specify: (()	hite
21215-0036 d within 72 hours after death w giene. r than "naturer", or frems 23a r the Medical Examiliar reasts.	Completed	15. Decedent's E (Specify only highest gro	ducation ade completed)	(Give kind	s Usual Occupation	on ing most of worki	ng 16b	. Kind of Business/	ndustry
Within than,	dm	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO	NDT use retired)	onist		Printi	ńq
d 2 filled 2 Hygie out, ent,		17. Father's Name (First, Middle, Last)	,,,,	18	B. Mother's Name	(First, Middle, Maid	den Sumame)	J
rlan uld be Aental rked (To Be	Erman	Burd			Nora	PoWe	.//	
Baltimore, Maryland 21215-0036 Bentimore, Maryland 21215-0036 Department of Health and Mental Hygiene, Importent: If them 27 is marked other than "neturel", or items 23s or 28s-1 shown yn jury or other treumstic event, the Medical Examinar mast be notified at once.		19a. Informant's Name/Relationship	Туре, Print)	19b. Mailing Ad	ddress (Street and	d Number or Rura	Dar Lingto	ty or Town, State, 2	^{Tip C} 21034
Baltimore, M permit. Pages 1 and 2 Department of Health Importent: if them 27 any nigray or other tre		CONSTANCE OVO 20a. Method of Disposition	ry Chaughter	Place of Disposition	- POO	CKa.	DELATE	Location - City or	0/4
Baltimore, Baltimore, Bernit, Pages 1 a Deportment of Hes mportent: if tem any nigry or othe		1 Burial 2 Cremation 3 \(\frac{1}{2} \) Donation 5 Other (Special Control of the	Removal from State	cemetery, cremato	ry`or other place)	el Avoist	2,2005 F	Drest H	il mo
Mit. P. Crten		21. Signature of Funeral Service Lice		22. Na	me and Address	of Facility Euc	ns Funera	I Chape	1-BEIAIT
Balt Balt Deports Imports any inj	İ	March Was	1	3 N	ewPort.	or. Force	st Hill, m	The second second	O
1.		23a. Part1. Enter the disease, or conshock, or heart failure. List only	notica wins that caused the dea	ath. Do not enter th	e mode of dying,	such as cardiac o	or respiratory arrest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	a. Renal	Failur	e				24 hours
/Medical Examiner		Todaking in dealing	Due to (or as a conse		schemi	z			24 Lines
	ē	Sequentially list conditions, if any leading to immediate	b. Due to or as a conse		SUMEMI	9			1
ocuted fransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c. Spina	1 Cord	Isch	emig			48 hours
760, A sician and se burdal-transit	cal Ex	resulting in death) Last	Due to (or as a conse	0	pheral	Vascu	lac Dis	ease	5-10 YPOIS
687 (687) illicate lilicate as the l	odlog		d. Sever	1611	Proceed	V 4,20 0		1420	7
369 ox 68 ox certificat broading phy use as th	Z/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		opic pregnancy			23d. Date of del	,
D. Bo Be death he atter	sicia	in the past 12 months?	4☐ Pregnant at time of 9☐ Unknown		ner (specify)			Month	Day Year
P.O. that the detache	by Physician/Medi	9 ☐ Unknown Part II. Other significant conditions	contributing to death but not re	sulting in the under	tying cause given	in Part I.	23e. Did tobac	co use contribute to	the cause of death?
v 8 5 8	d b						11/00	2□No 3⊡#	obably 4 \(\sum \)Unknown
Record he law requir	Completed						24a. Was an autopsy	24b. Were au	itopsy findings available completion of cause of
Re The light	l mo						performed	l? death?	2 □ No
Vital Sicien: Ti	Be	25. Was case referred to medical examiner?	Hospital:		Other.		(Check only one)		
Of Phy ral d	- T	1 ☐ Yes 2 ☑ No 27. Manne of Death	1 Minpatient 2L	☐ ER/Outpatient : 28b. Time of	28c. Injury a	at Nursing Ho	me 5 Residence 28d. Describe how i		cify)
	atlon	1 Matural 5 ☐ Pending 2 ☐ Accident investigate	28a. Date of Injury (Month, Day Year)	Injury	Work? M 1 ☐ Ye	s 2 □No			
Divisio	Certification:	3 Suicide 6 Could not determined	28e. Place of Injury - At building, etc. (Spec	home, farm, street,	factory, office		28f. Location (Stree City or Town, S	t and Number or Ri tate)	ural Route Number,
Div Div oitel or A ors after orel Direc								-(a) and manner as	a a tata d
DIVISION To the Hospitel or Attenwithin 24 hours after deat To the Funeral Director; completely filled in by the	Medical	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the best of my kr miner: On the basis of examir and manner stated.	nowledge, death oc nation and/or invest	gation, in my opir	, date and place, nion, death occurr	ed at the time, date	and place, and due	to the cause(s)
To the within To the compli	Me	29b. Signature and title of certifier	. 1		29c. License r	number	29d.	Date signed (Mont	h, Day, Year)
		11,44	Ruche	M.D.		15349		7/30/	105
4)	30. Name and address of person who	(0.1	em 23a) (Type, Prin	nt)	C . '4 =	301 R-	1 A. M	d. 21014
	ata	31. Date filed (Month, Day, Year)	Per Chesap 32. pegistrar's Sign	pake I	rive	JUILE	206,0001	7717 /110	1. 010/7
Regis	tate trar	AUG n 2 2	2005 Magaza	it Age	(i)				

			Please 3		nt in Black In			-	_	ble.	
		,	For State Registrar	State of M	laryland / Depa <i>Ce</i>	artment of H <i>rtificate of I</i>			giene 300. N2 N (15	25125
			Decedent's Name (First, Middle, Last	")				2. Date of Dea			3. Time of Death
	Physici		Greaison		Kispert			July 27	Day 2005	Year	8:13 P ^M
	/Medic Examir		4a. Facility Name (If not institution, give	street and number		4b. City, Town, or	Location of Death		4c. County	of Death	
1	Examili	er	Stella Maris Hos			Tim	onium		Ba1	timo	re
	Funeral		Social Security Number 6. Se	7. A	ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Da)			place (State or Foreign ntry)
	Director		215-09-5446	∃M 20XIF	88 Yrs.	Months Days	Hours Min.	Nov. 2	, 1916		yland
	ט		Usual Residence of Decedent								
	nylan how		10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show r nust be notified at	cto	MD Balti	more	Towson						1 ☐ Yes 2 📉 No
	or 28	ire	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Cou	ntry?
	th wi	a	1114 High Country	Road		21286			USA		
	dea Bms	ner	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Si	pecify Yes or No-	- 14. Rac Blac	e - Ameri	can Indian, etc.
9	or It	F	1 Never Married 2 Married	1 ☐ Yes 2 🔀	No	1□Yes 2X No			1	· Wh:	
S	ours rral',	d b	3 X Widowed 4 □ Divorced	Year or Dates:							
21215-0036	72 h	Completed by Funeral Director	15. Decedent's Edi (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of wor	king	16b. Kind of Bu	siness/in	idustry
121	vithin ne. han	dω	Elementary/Secondary (0-12)	College (1-4or	5+)		7		0	II	
2	iled v Hygie ther t		17. Father's Name (First, Middle, Last)	<u>L</u>	Ho	memaker	18. Mother's Nan	ne (First, Middle,		Home	e
anc	tall h	Be								-,	
Maryland	ould Mer nark	은	Louis Anderson	inna Daine)	10h Maili	ng Address (Street		y McManu		State 7	n Coda)
Mai	12 st h and 7 Is n traun		19a. Informant's Name/Relationship (7)						-		7 0000)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23s or 28s-1 show any injury or other traumatic event, If a Marical Examinet must be notified at ance.		George Kispert/S 20a. Method of Disposition	on	20b. Place of Dispe	High Cou		d Towso	n MD 2		own. State
altimore,	ges It of h		1 X Burial 2 ☐ Cremation 3 ☐		Dulanev	matory or other place Valley Gardens	(Augus	st 1,			
Ë	Pa tmen tant: jury		* 4 □ Donation 5 □ Other (Specify,	4 4	A STATE OF THE PARTY OF THE PAR	Commence of the Control of the Contr		05	Timon	ium,	MD
Bal	Departiment Departiment Departiment Departiment Departiment Department Depart		2.1. Signature of Funeral Service Licente	TOONET	L	2. Name and Addres emmon Fun	eral Home	e of Dul	aney Va	11ey	, Inc.
			Bryan	Wichary	110	O W. Pado	nia Road	Timoniu	m. MD 2	1093	Approximate
			23a. Part1. Enter the disease, or comp shock, or beart fallure. List only of	one cause on each	line.	ter the mode of dyin	g, such as cardiac	or respiratory ar	1031,		Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a COLON	CANCER						
	/Medical Examiner		16SUI(III) III GEALITY	Due to (or as	s a consequence of):						
	* a	_	Sequentially list conditions,	b. ——————							
LX	De tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a consequence of):						
9	ecuted and -transit	kamin	that initiated events resulting in death) Last	C	s a consequence of):				-		
50,	oe ex	Ě		Due to (or as	s a consequence or,						
68760,	hysik	dlca	•	d							
9 x	that the death certificate be exe ed by the attending physician a detached for use as the burial-I	Physician/Medical	IF FEMALE:	23c. If yes, outcome	a of pregnancy				204 5-4	4 -4-15.	
Вох	death o	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			Z30. Dai	e of deliv nth	Day Year
0	the de	ysic	1 ☐ Yes 2 X No 9 ☐ Unknown	9☐ Unknown	at time of death 32	Other (specify)					
<u>α</u>	that the ed by detac	P	Part II. Other significant conditions co	ontributing to death	but not resulting in the u	inderlying cause give	en in Part I.	23e. Did to	obacco use conti	ribute to t	he cause of death?
ŝ	signe	by	, <u></u>	g	•			101	′es 2 □ No	3 Pro	bably 4X Unknown
Records,	w requires that been signed to should be deta	Completed						-			
ec	a 5 C	J D						24a. Was autop	an 24b.	Vere auto prior to co leath?	ppsy findings available impletion of cause of
E .	Th ate pag	Con								Yes	2□ No
Vital	Physician: Th this certificate al director, pag	Be (25. Was case referred to medical examiner?				26. Place of Dea	th (Check only o	ne)		-
of V	Physic this ce al dire	2	1 ☐ Yes 2 至 No		ient 2 ER/Outpatie		4 Unuising n	ome 5□Resid			HOSPICE
0	ng Ph fter th neral		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inj (Month, Date)	ury 28b. Time o ay Year) Injury	Worl	k?	28d. Describe h	low injury occurr	be	
0	Attending r death. sctor: After	atio	2 Accident investigation			M 1 🗆	Yes 2 □No				
Division	r Att ter de irectu	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	288. Place of Ir	njury - At home, farm, st etc. (Specify)	reet, factory, office		28f. Location (S City or Tow	Street and Numb m, State)	ər or Rura	al Route Number,
	ital or its afte ral Dir led in	Certification:					0				
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	cai	29a. Certifier 1X Certifying Phy (Check only 2 Medical Exam	sician: To the bes	t of my knowledge, deat of examination and/or in	th occurred at the tin	ne, date and place	, and due to the o	cause(s) and ma	nner as s	stated. o the cause(s)
	the H in 24 the F nplete	ledicai	one)	and manner s							
	To 1 To 1	Σ	29b. Signature and title of certifier			29c. Licens			29d. Date signed		
			/ 7-			De	13725		7/	28/	05

Registrar

DR。 TARIQ MAHMOOD

31. Date filed (Month, Day, Year) State

2300 DULANEY VALLEY RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG 0 2 2005

TIMONIUM, MD 21093

			1 = For State Registrar	State of Ma	ryland		artment tificate			and Me	ntal Hyg	jiene .g. 2 00	5 2	25126	
	Physicia /Medic	an al	Decedent's Name (First, Middle, Last	Charles V	W. Kn	night					2. Date of Dea Month July	Day 27 2	Year .005	3. Time of Death 8:25 A. M	ı
	Examin	er	4a. Facility Name (If not institution, give Genesis Eldercar	e Hammond			Ba	1tim				4c. County o	Arun		
	Funeral Director		213 14 9330		83	ast birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	B. Date of Birth (Month, Day March 9	, 1922	9. Birthpla Count Mary	ace (State or Foreign y) land	7
	f ehow	ō	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Ar	undel		, Town or Lo							10	d. Inside City Limits	
	with the has or 28a-1	Direct	10e. Street and Number 413 Walton Ave:		12	OGI CIM	10f. Zip	Code 212	25		1	U.S.	hat Count	ry?	
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: if item 27 is marked other than "natural", or items 23a or 28a-f show strip highly or other traumatic event, The Medical Examinar must be notified at anone.	by Funeral Director	11. Marital Status 1 Xoever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent & Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates: V	lo		Was Deced f Yes, spec 1 ☐ Yes 2	ent of Hi ify Cuba	_		ify Yes or No- can, etc.)		- America , White, e	tc.	
Maryland 21215-0036	d within 72 hou jiene. r than "natura ine Medical E	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		+)	(Give	dent's Usua kind of wor DO NOT us Prviso	k done d e retired	ation Juring mos	t of working		16b. Kind of Bus			
land	12 should be filed within and Mental Hygiene. Fis marked other than "raumatic event, the Men	To Be C	17. Father's Name (First, Middle, Last) Winfi	eld Knight	t				18. Mothe	Isabe		Maiden Sumame (unk	onown)	
	1 and 2 shou Health and M tem 27 is mai		19a. Informant's Name/Relationship (T Rosemary Shomler				ng Address Valtor					r, City or Town, S re, Mary			-
Baltimore,	Pages 1 a nent of Her ant: if Item ury or othe		20a. Method of Disposition 1									20c. Location · 0	re, M	laryland	
Balt	permit. Page Department of important: if any injury or once.	21. Sixulure of Funeral Service Licensee 22. Name and Address of Facility Go. 4001 Ritchie Highwa												and 21225	5
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or exploitations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):											Approximate Interval Between Onset and Death	er.
8760,	ste be executed sysician and he burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause to sease or injury that initiated events resulting in death) Last	cDue to (or as a d			., , .			-					
P.O. Box 68	The law requires that the death certificete be executed ate has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pr Other (sp					23d. Date Mon		y Day Year	
	uires that I signed by Id be deta	by	Part II. Other significant conditions co	entributing to death be		ulting in the u	nderlying c	ause give	en in Part I	l.			bute to the	cause of death?	1
Records,	sician: The law requir certificate has been si irector, page 2 should	Completed									24a. Was a autop: perfor	sy pr med? de	ior to con eath?	sy findings available pletion of cause of	9
Vital	Physician: this certificatal director, p	Be	25. Was case referred to medical examiner?	Hospital:				Othe	ar .		Check only or				
of	ding Phy I. After this funeral d	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ∐ Inpatie 28a. Date of Injui (Month, Day		ER/Outpatier 28b. Time o Injury		8c. Injury Work	4 (271)	28		ence 6 □Othe ow injury occurre			
Division	F Si te	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubul			reet, factory	r, office		28	If. Location (S City or Tow	treet and Numbe n, State)	r or Rural	Route Number,	
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical (ysician: To the best of iner: On the basis of and manner sta	examinat						d at the time, o	date and place, a	nd due to	the cause(s)	
	To t withi	Σ	29b. Signature and title of certifier	n M	0			دم	number	06		29d. Date signed	201	2	
6	+11		30. Name and address of person who co	completed cause of d	eath (Item	23a) (Type,	Print)	ret.	feli	sm.	re /	6/1/	2/	2122	حر
	Sta Registi		31. Date filed (Month, Day, Year) AUG 0 2 2	32. P a jištra	ar's Signa	ture	book	,							
			AUU U & C	TOTAL PORTOR			CL								

		•	1 - For State Registrar	State of Marylan		artment of H		Mental Hy	rgiene	05 /	25127
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	Knech	1			2. Date of De Month	28	2.00.5	3. Time of Death
2000	Examin Funeral Director		5. Social Security Number 6. Sex	NUTSING TO Age (Inlyrs. I	ast birthday)	4b. City, Town, or Catov If Under 1 Year Months Days	Soile If Under 24 Hrs. Hours Min.	·	rth ay, Year)		
	D	o.	Usual Residence of Decedent 10a. State 10b. County MD Baltimore		y, Town or Lo						0d. Inside City Limits 1 ☐ Yes 2 ☒ No
	th with the N 23a or 28a-f	al Director	10e. Street and Number 5616 Southwestern		areciio	10f. Zip Code 21.227	,		10g. Citizen	of What Coun	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23s or 2ss-f show other traumatic event, Item Medical Expiritive man be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U. Armed Forces? □ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)	E	Race - Americ Black, White, e ecify: W	
21215-0036	within 72 ho iene. 'then "natur	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation com <i>pleted)</i> College (1-4or 5+)	(Give	dent's Usual Occupi kind of work done o DO NOT use retired naker	turina most of wor	rking		f Business/Ind n Home	lustry
Maryland 2	2 should be filed and Mental Hygic is marked other surmatic event, II	To Be C	17. Father's Name (First, Middle, Last) John Roy Hamburge		10h 14-iii			ette B.	Stab		Codel
	ss 1 and 2 sh of Health and I Item 27 is n r other traun		Ruth E. Farrell / 20a. Method of Disposition	daughter	1245	ng Address (Street a Poplar Aversition (Name of matory or other place	e Arbutu		land 2		***
Baltimore,	permit. Pages 'Department of P Important: If Ite any injury or of once.		1 ⊠ Burial 2 □ Cremation 3 □ Ri 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Library	New	22	edral Cem 2. Name and Addres 328 Sulph	s of Facility A	/1/2005 mbrose g Rd Ar	Funera1	Home,	Inc.
	Physician		23a. Pert1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	Do not en						Approximate Interval Between Onset and Death
3760, 🛠	te be executed hysicien and he burial-transit	ical Examiner	Sacue fiely list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last	Due to (or as a consequence to (or a) consequence to (or a) consequence to (or a) consequence to (or a) consequence to (or a)	uence of):						
.O. Box 68	The law requires that the death certifical tite has been signed by the attending phycage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ac. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	Ideath 3	⊒Ectopic pregnancy ∃ Other (specify)			23d.	Date of delive Month	ery Day Year
Δ.	w requires that been signed b should be deta	by	Part II. Other significant conditions con	STRUCTIVE	ulting in the u	nderlying cause givi LMONA/	a	23e. Did E7 E10	Yes 2□No	o 3 Prob	
Vital Records,		e Completed	25. Was case referred to medical	NELLITUS			26, Place of Dea	pert 1 ☐ Yes	2 No	death?	psy findings available mpletion of cause of
of	ng Phys ter this neral di	To B	eyaminer?	ospital: 1 Inpatient 2 Inpati	ER/Outpatier 28b. Time o Injury	f 28c. Injun Wor	er: 4 Dinursing H	dome 5 Res			1)
Division	oital or Atteurs after dearral Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	y) 			City or To	own, State)		l Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Medical	29a. Certifier Certifying Physical Check only 2 Medical Examination one)	ician: To the best of my kno er: On the basis of examina and manner stated.	tion and/or in	h occurred at the tin vestigation, in my o	pinion, death occu	e, and due to the urred at the time	, date and plac	manner as st ce, and due to gned (Mogth,	the cause(s)
	h		30. Name and address of person who so	mpleted cause of death (Item	23a) (Type,	POPU 1 IARK T	18195	A	Rai	28/0-	1 2 12 2
	Sta Regist		31. Date filed (Month, Day, Year) AUG 6 2, 2005	32. Registrar's Signa			101175	1116)	12/16	10 1011	301200

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 5 2. Date of Death 1. Decedent's Name (First, Middle, Last) 28 9:00 AT **Physician** KREMEN July ABRAHAM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE N/A 830 W. 40th STREET If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/17/1905 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Funeral Days Hours 100 MD Director 220-44-4773 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ehow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Mental Hygiene. Important: If item 27 le marked other then "netural", or itema 23e or 28a-f ehov any Injury or other treumetic event, I'm Medical Examiner must be notified at Y☐ Yes 2☐ No MD BALTIMORE N/A Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 830 W. 40th STREET 21211 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1□Yes 2X No WHITE Baltimore, Maryland 21215-0020 Specify. Specify: ģ 3 Nidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OPTHAMOLOGY 5+ OPTHALMOLOGIST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HYATT KREMEN SARAH ALEXANDER ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 5535 FORBES AVENUE APT. E - PITTSBURGH, PA 15217 DAVID KREMEN / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 07/31/2005 REISTERSTOWN, MD OHEB SHALOM MEMORIAL 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licens 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Enter the disease, or complicator heart failure. List only one **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical year Examiner Examiner After this certificate has been signed by the ettending physician and funeral director, page 2 should be detached for use as the burial-transit the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 XNo 3 Probably 4 □ Unknown 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 200 1 ☐ Yes 2 ☐ No or Attending Physicien: after death. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation after death.

Director: Aft d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Difference: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 28, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THETREGOR, 830 W 40 th STREET, BALTIMORE, M) 21211 M. IS ABELLE

Registrar's Signature

Registrar DHMH 16 Rev 6/95

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. N2. [] [] 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** pres 900 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospita Baltimore HODKINS lohns N/A If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. **Funeral** Months Days Hours 1**⊠**M 2□F 68 Director AUG 10 151-26-0147 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, Ite M dical Examiner and be natified at once. 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State 1 ☐ Yes 2 ☑ No Completed by Funeral Director MD Harford Joppatowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21085 USA 305 Rosecrest Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∑Yes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Non Commissioned Officer US Army 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be LoPresti Josephin Locarro Nicholas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Yoshiko LoPresti - wife 305 Rosecrest Court, Joppatowne, MD 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Arlington National Cem. 8/10/2005 Arlington, VA of Funeral Service Licensee 22. Name and Address of Facility CAFA, Stephen D. Lohrmann, 8717, Green Pastures Drive, PA Towson, MD M00986 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10 cardia dan **Physician** /Medical Due to (or as a consequence of). Examiner nonary an Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit bote the attending physicien and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Qid tobacco use contribute to the cause of death? δ ance Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 Certification: To 2 ER/Outpatient 3 DOA this Manner of Death 28b. Time of 28c. Injury at Work? Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 5 Pending investigation Vatural 1 ☐ Yes 2 ☐ No after death Director: / 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Funerel 24 hours Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 05-00

State

DHMH 17 Rev 1/2001

Registrar

arre and address of person who

AUG 0 2

31. Date filed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print)

gistrar's Signatura

32

2005

			1 = For State Registrar	State of Maryla		artment of F			iene 9. N 2 0 0	5 25130
	Physici	an	Decedent's Name (First, Middle, Last)	T 1				2. Date of Death Month	Day	3. Time of Death
	/Medic		Padraic Michael 4a. Facility Name (If not institution, give str	Lund		4b. City, Town, o	r Location of De	July	31 2 4c. County of	005 3:45 p M
	Exami	ier	408 Kershaw Road	,		Joppa	r cooditor of bo	1,00	Harfo	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs		If Under 1 Year Months Days	If Under 24 H		Year)	Birthplace (State or Foreign Country)
ķ.	Director		Usual Residence of Decedent	4 2 F 3	O Yrs.			MAY 14	1975	MD
	yland		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	a-f st	ctor	MD Harford	J	орра					1 ☐ Yes 2 🔀 No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	nat Country?
	18 238	erai	408 Kershaw Roa	. Was Decedent Ever in t	10 123		085	(S	US	
396	be filed within 72 hours after death with the Maryland hal Hygiene. Id other than "natural", or Itams 23a or 28a-f show other than "natural", or Itams 23a or 28a-f show event, it a Medical Exam for must be mortified at	by Funeral	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	'	f Yes, specify Cuba	Specify:	(Specify Yes or No- erto Rican, etc.)		- American Indian, White, etc. White
5-0	72 hor	Completed	15. Decedent's Educa	tion		dent's Usual Occup		rodkina 1	6b. Kind of Busi	
21	within 7 ene. than *	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. i	DO NOT use retired	during most of h	FORKING	T 1	
22	e filed within al Hygiene. other than '		17. Father's Name (First, Middle, Last)	<u>J</u>	50	udent	18 Mother's N	ame (First, Middle, M	Educa	
an	inould be ind Mental marked o	To Be	Roger Warner	Lund			Sally		alderi Sumame)	
Maryland 21215-0036	w C 3	-	19a. Informant's Name/Relationship (Type		19b. Mailin	ng Address (Street		Rural Route Number,	City or Town, St	ate, Zip Code)
	and 2 ealth a m 27 is		Sally Lund - mo				Road,	Joppa,	MD 21	085
lore	Pages 1 ar		20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Ren	noval from State	cemetery, cren	sition (Name of natory or other plac	·	Date 2	0c. Location - Ci	ity or Town, State
Baltimore,	Pa ant any		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Licensee.	Cha		Crematory . Name and Address		′3/2005 I	Beltsvil	le, MD
Ba	permit. Departr Imports any inju		K Sall	M0098		AFA, Ster	hen D	Lohrmann	PA T	21286 owson, MD
	· · · · · · · · · · · · · · · · · · ·		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the dea	1.0	er the mode of dyin	g, such as cardi	ac or respiratory arres	tve, i	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Asus tale	_					Onset and Death
	/Medical Examiner		resulting in death)	Due to (on as a consec	-		•			SCEOVES
	4	er	5-cuantially list conditions b if any, leading to immediate	Due to r as a consec	auence of):	nfarcher		7.10		minutes
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Durke	kve	Cardio	nicope	they		1. Cars
Ó,	cate be executed obysician and the burial-transit	Exa	resulting in death) Last	Due to (or as a consec	quence of):	11		, (
8760,	cate b physic the b	dicai	d) vale	nue	Muscle	ON D.	propri	7	years
9 xc	attending processing p	/Me	IF FEMALE: VA 23b. Was decedent pregnant 23c	. If yes, outcome of pregn	ancy M	A			23d. Date of	of dollars NA
P.O. Box	The law requires that the death certificate has been signed by the attending tage? should be detached for use as	Completed by Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 0 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	
œ,	res that igned b be deta	y PI	Part II. Other significant conditions contri	buting to death but not res	sulting in the ur	nderlying cause give	en in Part I.	23e. Did toba	icco usa contribi	ute to the cause of death?
ord	w require been sig should b	ted	Ventilalory ta	luca				1 ☐ Yes	2 € No 3	Probably 4 Unknown
Division of Vital Records,	e law r has be ge 2 sh	npie	-Quadriplegia	,				24a. Was an autopsy	prio	re autopsy findings available or to completion of cause of
a F	r: The							performe 1 Yes 2		ith? Yes 2□ No
ξ	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	pital: 1 ☐ Inpatient 2 ☐	15D/O-1	Othe		eath (Check only one)		
10	g Phy er this eral d	n; To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury	at 1/.	Home 5 Residen 28d. Describe how		(Specify)
ior	ttendin death. stor: Att	atio	2 Accident investigation	NOMM, Day Year)	N A	M 1 🗆 Y	? NA Yes 2 □No	NA		
i	for Atter de Directo	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	et and Number (State)	or Rural Route Number,
	Hospital (24 hours a Funeral Distely filled i		29a. Certifier 1 Certifyin Physic	lam: To this best of my kno	- A	A	- 4-1		<i>N</i> .	1
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificale ha completely filled in by the funeral director, page	edical	(Check only 2 Medical Examiner one)	On the basis of examina and manner stated.	ation and/or inv	estigation, in my op	pinion, death oc	curred at the time, date	e and place, and	I due to the cause(s)
	To the lead that within 24 To the F complete	Me	29b. Signature and title of certifier	1000		29c. License	_	!	d. Date signed (A	Month, Day, Year)
3:	A	- 5	Milale	A A	Hendin	RianHoc	348214	+	8/1/.	2005
	<i>'</i>	1 15	30. Name and address of person who comp	oleted cause of death (Item	п 23a) (Туре, Г	Print)	MILLIES	it Prw	y BA	21218
	Sta	te_	31. Date filed (Month, Day, Year)	32. Registrar's Signa			1110010		0	
	Registr		Alle and							

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of M	larylan	-	artment of		nd Mental Hy	_	00=	05101
			Registrar 1. Decedent's Name (First, Middle, Las	et)		Ce	illicate of	Dealli	2. Date of D	Reg. No.	005	3. Time of Death
	Physici		James Finis Lake	"7					JULY	7 Ci	2005	9:25 A.M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number	7)		4b. City, Town,	, or Location of		4c. C	ounty of Death	
	Examili	ei	Baltimore Washingt			nter	Glen Bu				nne Aru	
	Funeral		5. Social Security Number 6. Se	9x 7. A		last birthday)	If Under 1 Yea	r If Under 24	Hrs. 8. Date of B			hplace (State or Foreign
	Director		201–18–0226	∑ M 2□F	79	Yrs.	Months Day	s Hours	Min. 8. Date of Bi (Month, D Sept. 2	1, 192!	5 Penr	nsylvania
	pul *		Usual Residence of Decedent 10a, State 10b, County		10c Cit	ty, Town or Lo	eation					10d. Inside City Limits
	sho	'n	,				Catton					1 ☐ Yes 2 ☐ No
	the N	ect	Maryland Anne Aru	indel	Pasa	adena	10f, Zip Code			10a Citiza	en of What Co	
	with Sa or	i D	226 Glen Road				211				J.S.A.	and y:
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-1 show I.a M.cifell Exciptor must be multing at	Funeral Director	11. Marital Status	12. Was Deceden			Was Decedent of	Hispanic Origin	n? (Specify Yes or N		I. Race - Amei	
တ	or Ite	Ē	1 Never Married XX Married	Armed Forces 1 GYes 2 ☐ IFYes, Give	No 19	44-			Puèrto Rican, etc.)		Black, White	a, etc.
8	ral', c	by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	19	46	1□Yes XXN	o Specify:		S	Specify: Wh	nite
21215-0036	72 h	Completed	15. Decedent's Ed (Specify only highest gra			(Give	dent's Usual Occ	e durina most d	of working	16b. Kind	d of Busin <i>e</i> ss/l	industry
2	han han	Idm	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOT use retii	red)				
i N	Hygie Hygie Thar t		10 17. Father's Name (First, Middle, Last)			Rolle	<u> </u>	18 Mother's	Name (First, Middle		nlehem	Steel
and	ntal Ped ol	Be	Elbert F. Lake						Grace St		umame)	
Maryland	thould Me	은	19a. Informant's Name/Relationship (7	Type. Print)		19b Mailir	ng Address (Stre	et and Number	or Rural Route Numi	her City or i	Town State 7	in Code)
Z Z	nd 2 s ith ar 27 is r trau		Mary Lorraine Lake				-		dena, Mar	-		,,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
<u>6</u>	F Hearlitam		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of matory or other p		Date		ation - City or 1	Town, State
ê	Page: ent o nt: If		1 🔀 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify		9	-	of Faith	· 1	g.2,2005	Ralti	imore	Maryland
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic evant. It is Medical Examination at the multilised at Once.		21. Signature of Funeral Service Licen		, 550		2. Name and Add	ress of Facility				*
m	Departing Department of the part of the pa	(1350			1411	1407 Old	ruzazın Faster	ski Funera n Avenue,	al Hon Essex	ne, P.A . Marv	land 21221
П			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that cause one cause on each	ed the deat line.							Approximate Interval Between
	Physician [*]		Immediate Cause (Final disease or condition	HEPA	-TO C	ELLIN	AR	CARCI	MMA.			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	s a conseq	juence of):	.,.					
П	CXAIIIIIIEI	_	Sequentially list conditions,	b								
	ed sit	ine	it any, leading to immediate cause. Enter Underlying	Due to (or as	s a conseq	uence of):						
` .	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	s a conseq	uence of);					-	
8760,	be e sician buria	aiE		,		,						
687		edicai		d								
Вох	The law requires that the death certific at has been signed by the attending prage 2 should be detached for use as	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			3-			23	d. Date of deli-	very
Ď.	death e atte	icia	in the past 12 months?	1☐Live birth 4☐Pregnant a]Ectopic pregnan] Other <i>(specify)</i>				Month	Day Year
Р. О.	at the by th tache	Physician/M	9 🗆 Unknown	9□ Unknown								
	es th; gned be de	by F	Part II. Other significant conditions co	ontributing to death	but not res	ulting in the u	nderlying cause g	given in Part I.		V	1	the cause of death?
ord	w require been sig should b	ted							_ 10	Yes 2	No 3□Pro	obably 4 Unknown
Records,	taw ras be	Completed							24a. Was	s an	24b. Were aut	topsy findings available completion of cause of
	The ate h	Con							perf 1 ☐ Yes	ormed? 2 X No	death?	
Vita	cian: ertific ector,	Be	25. Was case referred to medical examiner?	Hamitalia a					f Death (Check only	one)		
of	Physic this cal dire	L To	1 Yes 2 No	Hospital: Inpati					ing Home 5 □ Res			ify)
ב	ding I	ion	27. Manner of Death 1 Natural 5 ☐ Pending	(Month, Da	ay Year)	28b. Tim <i>e</i> or Injury	W	uryat ork? □Yes 2 □No	28d. Describe	now injury o	occurred	
Division of	or Attanding Physician: ufer death. Diractor: After this certific in by the funeral director.	ficat	2 Accident investigation 3 Suicide 6 Could not be		niury - At ho	om <i>e</i> farm str	eet, factory, office			Street and	Number or Ru	rai Route Number,
<u> </u>	after Dira	Certification:	4 ☐ Homicide determined	building, e	tc. (Specif	(y)	oot, ractory, onlo		City or To	wn, State)		.,
	spita hours narah y filled		29a. Certifier 1 Certifying Physics	ysician: To the best	t of my kno	wledge, deati	occurred at the	time, date and	place, and due to the	cause(s) a	nd manner as	stated.
	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical Exam	niner: On the basis of and manner s	of examina	ition and/or in	vestigation, in my	opinion, death	occurred at the time.	date and p	lace, and due	to the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier		1 -		29c. Lice	nse number		29d. Date	signed (Month	, Day, Year)
	- 11		Acto		M		124	3777		July	292	wos
	1271		30 Name and a dress of person who of	completed cause of	death (Iten	n 23a) (Type,	Print) A.I.	R	S	101	01-1	
	1 ,	10-27	Myden Myn	p. 301 ft	Bert	N UR	in cus	n Bun	ME: Wo	1	001.	

Registrar DHMH 17 Rev 1/2001

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Man		artment of F rtificate of			iene 2.00	5	2513	3
	Physici /Medic		Decedent's Name (First, Middle, Last) Berlise		Ma	son		2. Date of Dea Month	th Day	Year 005	3. Time of De 2:a	ath M
	Examir		4a. Facility Name (If not institution, give s Future Care N	.н.		Balti	r Location of Death		4c. County	of Death		
	Funeral Director		5. Social Security Number 6. Security S	7. Age (III	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 2-14-	Year)	9. Birth	place (State or Fo	_
	Maryland -f show	tor	10a. State 10b. County Md.	N A	C. City, Town or Lo	cation Baltimore	9				10d. Inside City L	
	with the 3a or 28a	i Director	10e. Street and Number 2236 W. Saratog	a Street		10f. Zip Code 212	223	1	0g. Citizen of V	Vhat Cou	ntry?	
980	be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or ttams 23a or 28a-f show avent, the Medical Evarting must be rodified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	}	Was Decedent of H f Yes, specify Cubin	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		k, White,	can Indian, etc. ack	
Maryland 21215-0036	e filed within 72 ho al Hygiene. I other then "natur vent, the Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 8th grade		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wor	king	16b. Kind of Bu		_{dustry}	
land ?	should be filed and Mental Hygid s marked othar umatic avent, II.	To Be C	17. Father's Name (First, Middle, Last) Henry		Butle		18. Mother's Nam	ne (First, Middle, I	Maiden Surnam			
Mary	s 1 and 2 should be f Health and Mental item 27 is marked othar traumatic av	-	19a. Informant's Name/Relationship (Ty	ов, Print) Son			and Number or Ru	ral Route Number	, City or Town,	State, Zip		
Baltimore,	Pages 1 and 2 ent of Health a nt: If item 27 Is ry or other trau		20a. Method of Disposition 1		20b. Place of Dispo cemetery, cren		(e)	Date	20c. Location -	City or To		
Baltii	permit. Pages. Department of P Important: If ite any injury or of		21. Signature of Funeral Service License	Cook	22	Mem. Pa Name and Addre March F.	ss of Facility	Balt	imore, E. Nor	Md.	21202	
8760,	death certificate be executed x x x X X X X X X X X X X X X X X X X	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Linus fundarilying Cause (Disease or Injury that initiated avents resulting in death) Last	Due to (or as a co	pnsequence of):	1.	MUN () M		est,	(Approximate interval Betwee Onset and Dear	
P.O. Box 6	the death certific y the attending p iched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mor	e of delive	ery Day Year	r
	w requires that been signed b should be deta	by	Part II. Other significant conditions con	tributing to death but of	ot resulting in the ur	nderlying cause giv	en in Part I.			ibute to th	ne cause of death	
Il Records,	The law ate has b page 2 sl	Completed		ypertens	un_			24a. Was an autops perform	y ned2 d	Vere auto rior to co eath?	psy findings avai npletion of cause 2 No	ilable e of
Division of Vital	Attending Physician: Th r death. actor: After this certificate by the funeral director, pag	tlon: To Be	25. Was case referred to redical examiner? 1 Yes 2 No 27. Manne of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatien 28b. Time of Injury	28c. Injur	er: 4 Jursing Ho	th (Check only only only only only only only only	nce 6 Othe		r)	
Divis		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (5	At home, farm, stre Specify)	eet, factory, office		28f. Location (Sti City or Town	reet and Numbe , State)	er or Rura	l Route Number,	
	To the Hospital or within 24 hours after To the Funaral Discompletely filled in	edical (29a. Certifier 1 Certifying Physical Check only 2 Medical Examin	ician: To the best of mer: On the basis of exa and manner stated	amination and/or inv	occurred at the tin restigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	iuse(s) and mai ate and place, a	nner as st ind due to	ated. the cause(s)	
)	To the within 2 To the complet	W	29b. Signature and title of certifier	mo		29c. Licenso			7/28			
F)		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type,	/838	27564 Green	e Tree	Rd	21	205	
	Sta Registr		31. Date filed (Morfin, Day, Year) AUG 0 2 2	32. Registrar's	Signature	cark						

			State of Marylan	d / Department of Healt		giene
			Registrar	Certificate of Dea	2. Date of De	Reg. No. 2 0 5 2 5 3 Lath 3. Time of Death
	Physicia	in	1. Decedent's Name (First, Middle, Last) Mess. Mill	ler	Month	8, 2005 Year 1:20 P _M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Locat	ion of Death	4c. County of Death
26			14904 MANOR ROAD 5. Social Security Number 6. Sex/ 7. Age (In yrs. 1)	MONKTON ast birthday) If Under 1 Year If Un	nder 24 Hrs. 8. Date of Birt	BALTIMORE CO th 9. Birthplace (State or Foreign
194	Funeral Director	(056-80-2982+ 18M 20F 5L	Yrs. Months Days Hou		22.951 CANADA
	and land		Usual Residence of Decedent 10a. State 10b. County 10c. City	r, Town or Location		10d. Inside City Limits
	a-fah	ctor	MD Baltimore	nonkton		1 ☐ Yes 2 M No
	with th	Funeral Director	10e. Street and Number	10f. Zip Code	1	10g. Citizen of What Country?
	death	nera	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	S. 13. Was Decedent of Hispanic If Yes, specify Cuban, Mer	c Origin? (Specify Yes or No xican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. Item 27 is marked of Hygiene. Item 27 is marked of Hygiene instural; or items 23s or 28s-f show other than "natural; or items 23s or 28s-f show other traumatic event, the Madical Exam at must be notified at	by Fu	1 Never Married 2 Married 1 Yes 2 TVo 1 Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Spe		Specify: White
Maryland 21215-0036	72 hou natura		15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during	most of working	16b. Kind of Business/Industry
121	within ene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	meat Co	Her	Grant Food
nd 2	be filed tal Hygi d other event, I	BeC	17. Father's Name (First, Middle, Last)	18. N	Nother's Name (First, Middle	, Maiden Sumame)
ylaı	2 should be and Mental is marked of aumatic eve	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and No	UMBer or Rural Route Numb	er, City or Town, State, Zip Code)
	and 2 sl lealth and m 27 is r her traur		19a. Informant's Name/Relationship (Type, Print) (Wife)	14904 man	or rd. mo	nktromo 21111
Baltimore,			1 Burial 2 DCremation 3 Removal from State	lace of Disposition (Name of emetery, crematory or other place)	JULY 31	20c. Location - City or Town, State
Iţim	Part and		4 Donation 5 Other (Specify)	22. Name and Address of F	acilit Depos de l	ternanves forteral &
Ba	permit. Departr Importa		LOOK YOR	cremation a	enter 2325 Y	Orkra. Timonium, mo 21693
7.8			23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only or e-cause on each line.			
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence)		environmental h	yperthermie
l.	Examiner		Sequentially list conditions. b.			
4	pet list	niner	if any, leading to immediate Due to (or as a consequence) cause. Enter Underlying Cause (Disease or injury	uence of):		
0,	be executed sicien and burial-transit	Exami	that initiated events c	uence of):		
8760	cate be physici the bu	dicai	d			
Box 6	leath certifica attending ph I for use as tl	n/Me	IF FEMALE: 23c. If yes, outcome of pregn. 23b. Was decedent pregnant 1 □ Live birth 2 □ Feta			23d. Date of delivery
O. B	The law requires that the death certificate be executed ate has been signed by the attending physicien and oage 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 9 □ Unknown			Month Day Year
Δ.	es that the digned by the be detached		Part II. Other significant conditions contributing to death but not res	ulting in the underlying cause given in f	Part I. 23e. Did	tobacco use contribute to the cause of death?
ords	w require: been sign should be	ted b	Chronic alcohol abuse		1 🗆	Yes 2 No 3 Probebly 4 Unknown
of Vital Records,	e lawr has be ge 2 sh	Completed by			24a. Was auto	prior to completion of cause of death?
tal		a)	25. Was case referred to medical	26.	Place of Death (Check only	2 □ No 1 Ves 2 □ No one)
Ž	Physician: this certificantal director,	To B	examiner?	Othor	□ Nursing Home 5 □ Res	idence 6XX ther (Specify) SCENE
o u	D - 0		27. Manner of Death 1 Natural 5 Pending (Month, Day Year)	28b. Time of linjury at Work?	101111111111	how injury occurred exposed to high
Division	Attendi death octor: A	Certification:	2 Accident investigation from 7/2e/05 6 Could not be determined 28e. Place of Injury - Ath	ome, farm, street, factory, office	28f Location	(Street and Number or Rural Route Number
ā	ital or A irs after ral Directled in by			sienes	Mondan	
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical	29a. Certiflier (Check only one) 1□ Certifying Physician: To the best of my kn (Check only one) 2▼ Medical Examiner: On the basis of examiner and manner stated.	wiedge, death occurred at the time, da ition and/or investigation, in my opinion	ate and place, and due to the n, death occurred at the time.	e cause(s) and manner as stated. , date and place, and due to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License num		29d. Date signed (Month, Day, Year) JULY 29, 2005
	, 2		Yamet Douthalk NO	O C I		
	10		30. Name and address of person who completed cause of death (Ite Powelu E Southall Ma)		REET, BALTIMO	RE, MARYLAND, 21201
	Sta Regist	ate	31. Date filed (Month, Day, Year) AUG 0 2 2000	ature posts		
* 4	inegist	rai	AUG 0 2 2003	-/		

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** A ^M 2005 Howard Melvin Merson, Jr. August 1, 1:15 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 10650 Harding Road Laurel Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Aug 2, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□F 1938 Director 218-34-5655 66 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Modical Examitmen must be notified at 1 ☐ Yes 2 XNo Director Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10650 Harding Road 20723 U.S.A. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1956-60 filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2K No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry County School Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other thsn ury or other traumatic event, ITEM. Elementary/Secondary (0-12) College (1-4or 5+) System 12 Electrician 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Howard Melvin Merson Audrey Lee Souder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10650 Harding Road, Laurel, Maryland 20723 Alicia Merson /spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department of important: If sny injury or once. ' 4 □ Donation 5 □ Other (Specify) Arundel Crematory Aug 5, 05 Odenton, Maryland W. 21. Signature of Funeral Service License 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20/0/-4389 M00773 itt 23a. Part1. Ent. the first se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or lead fall re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Firal disease or condition resulting in death) CONGESTIVE HEART FAILURE **Physician** I WEEK /Medical Due to (or as a consequence of): Examiner ISCHEMIC CARDIOMYOPATHY YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit HILLERTENSION JEHES and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physicien Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death ō in the past 12 months? Month Day Year 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe ANTERIOL PAINAL CORN DISEASE; KIDNEY 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 2 should Completed Deen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No INFARCTION: VENTRICULARTACHYCARDIA 24a. Was an has autopsy performed 2 No this certificate HYAFRLI AIDEMIA 1 Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of or Attending After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation To the Hospital or Attend within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 138296 AUG 1, 2005 Gm 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LARK BROWN RD, SUITE 201, ELKRIDGE, MD 21075 1 H43501 GIBBONS, W 8186 31. Date filed (Month, Day, Year) 82. Registrar's Signature State AUG 0 2 2005

DHMH 17 Rev 1/2001

Registrar

			for State	State of Maryla					~ ~ ~ ~	25126
			Registrar 1. Decedent's Name (First, Middle, La.	st)	Cei	rtificate of L	Jeath	2. Date of Death	<u>2005</u>	3. Time of Death
	Physici			rello				Month	29, 2005	6:35 A M
	/Medic Examin		4a. Facility Name (If not institution, give	•		4b. City, Town, or	Location of Death		4c. County of Deat	
			12 Juliet Lane,				imore		Baltimo	
	Funeral Director		217-02-0883	ex	. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,) July 5,	9. Birti 1915 W.	nplace (State or Foreign untry) Virginia
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity. Town or Lo	cation				10d. Inside City Limits
	Maryl i-f sho	ţō	Maryland Baltimo	ie .		Balt	imore			1 □Yes 2 No
	th the or 28a e notii	irec	10e. Street and Number			10f. Zip Code		109	g. Citizen of What Co	untry?
	ath wi	rai	12 Juliet Lane,				21236		u.s.A.	
36	be filed within 72 hours after death with the Maryland ital Hygiene. od other then "natural", or itams 23a or 28a-f show evant, the Medical Exeminer must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 Ⅸ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
5-0036	2 hour atural	ted k	15. Decedent's Ed	ducation	16a. Dece	dent's Usual Occupa	ition	16	6b. Kind of Business/I	
21215	2 should be filed within 7: and Mental Hygiene. Is marked othar than "n aumatic evant, the Med	Completed	(Specify only highest gra Elementary/Secondary (0-12) 7th Grade	College (1-4or 5+)	life. I	kind of work done d DO NOT use retired, OMEMARET	uring most of worki)	ing	Own Hom	16
פ	m - 0 %	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name		aiden Sumame)	
Maryland	ould be Mental Marked o	힏		illis			Virgin		Parker	
a Z	id 2 sh th and 27 Is n traun		19a. Informant's Name/Relationship (Ms. Tina Mennello	** * *					City or Town, State, Z imore, MD	ip Code) 21236
ē,	s 1 and Heal		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of natory or other place			oc. Location - City or 1	
altimore,	Page nent o ant: If ury or		1 🌠 Burial 2 □ Cremation 3 □ `4 □ Donation 5 □ Other (Specify	Removal from State	. Josep	oh Ch. Cen	n. 8/01		illerton,	
Balt	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or othar traumatic es		21. Signature of Funeral Service Licer	ille.					ineral Hom , MD 21236	
	₹*		23a. Part 1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.	, such as cardiac c	or respiratory arres		Approximate Interval Between		
	Physician (Madieal		Immediate Cause (Final disease or condition resulting in death)	a. ASP	ratio	~ pro	umon	la		6 weeks
	/Medical Examiner			Due to (or as a conse	quence of):	1				
	Whe.	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conse	quence of):					
<	acuted ind transii	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c					/	
8760,	ficate be executed physician and is the burial-transit		Todaking in double, Euck	Due to (or as a conse	quence of);				a ab	
687	ificate g phys as the	edicai		. d.					امنيا	
Box	th cert ending r use a	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn		Ectopic pregnancy			23d. Date of deliv	
o.	The law requires that the death certificate ate has been signed by the attending phys bage 2 should be detached for use as the	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown		Other (specify)			Month	Day Year
S,	es tha igned l	by P	Part II. Other significant conditions of	ontributing to death but not re-	sulting in the ur	nderlying cause give	n in Part I.		cco use contribute to	V
ord	w require been sig should b	eted						1 □ Yes	2 No 3 Pro	bably 4 Unknown
Il Records,	Physician: The law r this certificate has b ral director, page 2 s	Completed						24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
Viita	certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Death			
o	y Phys er this eral di	n; To	1 ☐ Yes 2 🕅 No 27. Manyer of Death	28a. Date of Injury	ER/Outpatien 28b. Time of	I J DOA	4 Nuising rior	ne 5 💢 Resideno 28d. Describe how	ce 6 Other (Speci injury occurred	ify)
ion	ath. or: After ne funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury		? ′es 2 □ No			
Division of	tal or Atte	Certification	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stre	eet, factory, office	2	28f. Location (Stree City or Town,	et and Number or Rui State)	ral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director, go	Medical	29a. Certifier (Check only one) (Check only one)	ysicien: To the best of my kn niner: On the basis of examin- and manner stated.	owledge, death ation and/or inv	occurred at the tim restigation, in my op	e, date and place, a inion, death occurre	and due to the caused at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
	with To 1	Σ	29b. Signature and title of certifier	Ac		29c. License	number		I. Date signed (Month)	
	1		30 Name and address of access the	completed course of death ():-	m 22a) /T	V 37	6/2	اً اِ	ly 29-	. 200)
	V		30, Name and address of person who have the same and address of person who have the sa	CH, MO	1601	5. 10/19	ate Rd	Belt	HR M	021015
	Sta Registr		AUG 0 2 20	32 degistrar's Sign	b. Jo	rele				

Democrate have first Authorities and stores and number Moody Line Stores S				1 - State of Maryland / De State of Maryland / De State of Maryland / De Per FH C846 8	epartment of Health and M	ental Hygien	e ann =	25127
Privacian Particular Control Development Contr					John Cale of Boats		<u>CUU3</u>	3. Time of Death
The John's Hundry of State 2017 Property 6. See Section Property 6. Section Property 6. Section Property 6. Section Property 6. Section Property 6. Section Property 6. Section Property 6. Section Property 6. Section Property 6. Section Property 6. Section Property 6. Section Property 6. Section Property 6. Section Property 6. Section Property 6. Section Property 6. Section Property 6. Section Property 6. Sectio		_	_	AA 1 /			-	12.2. A.M
Source design framework of personal property of the control of the		Examin	er	T T 1 11 1 11 11		4	c. County of Deat	th
The part of the pa				5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	day) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	9. Birt	hplace (State or Foreign buntry)
(Specific of the control of the cont		aryland show)r	10a. State 10b. County 10c. City, Town of				
(Government of rook and arrang most of working) (Government of rook and arrang most o		r 28a-f	Irecto			10g. C	Citizen of What Co	
(Specific of the control of the cont		sath wit		100 1100	21218	L	LSA	rings ladios
(Government of rook and arrang most of working) (Government of rook and arrang most o	980	ours after de el', or item Evantratr	by	Amed Forces? 1 Never Married 2 Married In Yes, Sive	If Yes, specify Cuban, Mexican, Puerto I	cry Yes or No- Rican, etc.)	Black, Whit	
198. Making Address (Sirest and Number or Plant Route Number, City or Town, State, Zp Cooks) 199. Making Address (Sirest and Number or Plant Route Number, City or Town, State, Zp Cooks) 190. Missaled States (Sirest and Number or Plant Route Number, City or Town, State, Zp Cooks) 190. Missaled States (Sirest and Number or Plant Route Number, City or Town, State, Zp Cooks) 190. Missaled States (Sirest and Number or Plant Route Number, City or Town, State, Zp Cooks) 190. Missaled States (Sirest and Number or Plant Route Number, City or Town, State, Zp Cooks) 190. Missaled States (Sirest and Number or Plant Route Number, City or Town, State, Zp Cooks) 190. Missaled States (Sirest and Number or Plant Route Number, City or Town, State, Zp Cooks) 190. Missaled States (Sirest and Number or Plant Route Number, City or Town, State, Zp Cooks) 190. Missaled States (Sirest and Number or Plant Route Number, City or Town, State, Zp Cooks) 190. Missaled States (Sirest and Number or Plant Route Number, City or Town, State, Zp Cooks) 190. Missaled States (Sirest and Number or Plant Route Number, City or Town, State, Zp Cooks) 190. Missaled States (Sirest and Number or Plant Route Number, City or Town, State, Zp Cooks) 190. Missaled States (Sirest and Number or Plant Route Number, City or Town, State, Zp Cooks) 190. Missaled States (Sirest and Number or Plant Route Number, City or Town, State, Zp Cooks) 190. Missaled States (Sirest and Number or Plant Route Number, City or Town, State, Zp Cooks) 190. Missaled States (Sirest and Number or Plant Route Number, City or Town, State, Zp Cooks) 190. Missaled States (Sirest and Number or Plant Route Number or Plant Route Number, City or Town, State, Zp Cooks) 190. Missaled States (Sirest and Number or Plant Route Number, City or Town, State, Zp Cooks) 190. Missaled States (Sirest and Number or Plant Route Number, City or Town, State, Zp Cooks) 190. Missaled States (Sirest and Number or Plant Route Number, City or Town, State, Zp Cooks) 190. Missaled States (Sirest an	1215-0	within 72 ho sne. Ihan "natur	mpleted	(Specify only highest grade completed) ((Give kind of work done during most of workir	ng 16b.	Kind of Business	Industry
200 Deare of Disposition (Series) 200 Deare of Disposition (Series) 200 Deare of Disposition (Series) 200 Deare of Disposition (Series) 200 Deare of Disposition (Series) 200 Deare of Disposition (Series) 200 Deare of Disposition (Series) 201 Deare of Disposition (Series) 202 Deare of Disposition (Series) 203 Deare of Disposition (Series) 204 Deare of Disposition (Series) 205 Deare of Disposition (Series) 206 Deare of Disposition (Series) 207 Deare of Disposition (Series) 208 Deare of Disposition (Series) 209 Deare of Disposition (Series) 200 Deare of Disposition (Series) 200 Deare of Disposition (Series) 200 Deare of Disposition (Series) 201 Deare of Disposition (Series) 202 Deare of Disposition (Series) 203 Deare of Disposition (Series) 204 Deare of Disposition (Series) 205 Deare of Disposition (Series) 206 Deare of Disposition (Series) 207 Deare of Disposition (Series) 208 Deare of Disposition (Series) 209 Deare of Disposition (Series) 209 Deare of Disposition (Series) 200 Deare of Disposition (Series) 200 Deare of Disposition (Series) 200 Deare of Disposition (Series) 201 Deare of Disposition (Series) 202 Deare of Disposition (Series) 203 Deare of Disposition (Series) 204 Deare of Disposition (Series) 205 Deare of Disposition (Series) 206 Deare of Disposition (Series) 207 Deare of Disposition (Series) 208 Deare of Disposition (Series) 209 Deare of Disposition (Series) 209 Deare of Disposition (Series) 209 Deare of Disposition (Series) 209 Deare of Disposition (Series) 200 Deare of Disposition (Series) 200 Deare of Disposition (Series) 209 Deare of Disposition (Series) 200 Deare of Disposition (Series) 200 Deare of Disposition (Series) 200 Deare of Disposition (Series) 200 Deare of Disposition (Series) 201 Deare of Disposition (Series) 202 Deare of Disposition (Series) 203 Deare of Disposition (Series) 204 Deare of Disposition (Series) 205 Deare of Disposition (Series) 206 Deare of Disposition (Series) 207 Deare of Disposition (Series) 208 Deare of Dis		td be filed v ental Hygie ked other i	Be		18. Mother's Name	(First, Middle, Maide	an Sumame)	
200 Deare of Disposition (Series) 200 Deare of Disposition (Series) 200 Deare of Disposition (Series) 200 Deare of Disposition (Series) 200 Deare of Disposition (Series) 200 Deare of Disposition (Series) 200 Deare of Disposition (Series) 201 Deare of Disposition (Series) 202 Deare of Disposition (Series) 203 Deare of Disposition (Series) 204 Deare of Disposition (Series) 205 Deare of Disposition (Series) 206 Deare of Disposition (Series) 207 Deare of Disposition (Series) 208 Deare of Disposition (Series) 209 Deare of Disposition (Series) 200 Deare of Disposition (Series) 200 Deare of Disposition (Series) 200 Deare of Disposition (Series) 201 Deare of Disposition (Series) 202 Deare of Disposition (Series) 203 Deare of Disposition (Series) 204 Deare of Disposition (Series) 205 Deare of Disposition (Series) 206 Deare of Disposition (Series) 207 Deare of Disposition (Series) 208 Deare of Disposition (Series) 209 Deare of Disposition (Series) 209 Deare of Disposition (Series) 200 Deare of Disposition (Series) 200 Deare of Disposition (Series) 200 Deare of Disposition (Series) 201 Deare of Disposition (Series) 202 Deare of Disposition (Series) 203 Deare of Disposition (Series) 204 Deare of Disposition (Series) 205 Deare of Disposition (Series) 206 Deare of Disposition (Series) 207 Deare of Disposition (Series) 208 Deare of Disposition (Series) 209 Deare of Disposition (Series) 209 Deare of Disposition (Series) 209 Deare of Disposition (Series) 209 Deare of Disposition (Series) 200 Deare of Disposition (Series) 200 Deare of Disposition (Series) 209 Deare of Disposition (Series) 200 Deare of Disposition (Series) 200 Deare of Disposition (Series) 200 Deare of Disposition (Series) 200 Deare of Disposition (Series) 201 Deare of Disposition (Series) 202 Deare of Disposition (Series) 203 Deare of Disposition (Series) 204 Deare of Disposition (Series) 205 Deare of Disposition (Series) 206 Deare of Disposition (Series) 207 Deare of Disposition (Series) 208 Deare of Dis	Mary	d 2 should the and M	F	19a. Informant's Name/Relationship (Type, Print)	Mailing Address (Street and Number or Rura	I Route Number, City	or Town, State, 2	Zip Code)
Physician (Indexided Examiner) Physician (Indexided Examiner)		e ° = 5		Burial 2 Cremation 3 Removal from State	crematory or other place)	B-1-05	Location - City or	Town, State
Physician (Indexided Examiner) Physician (Indexided Examiner)	altim						20170.1	Sparice &
Physician (Aledical Examiner) To get a consequence of the continue and th	<u>B</u>		117	23a Part Enter the disease or complications that caused the death. Do no	49057 JOH	Ld . Br		21212
Due to (or as a consequence of): Security ×			Immediate Cause (Final	tomer the mode of dying spon as cardiac o	respiratory arrest,		Interval Between Onset and Death	
Sequentially list conditions. Sequentially list conditions. Due to (are as a consequence of): Chromic As, and pro- Due to (or as a floresquence of): Chromic As,				Due to (or as a consequence of)):			7
The first of the second properties of the seco	-	sit sit	lner	Sequentially list conditions				- 9043
FFEMALE 1 1 23c. If yes, outcome of pregnancy 23d. Date of delivery	o,	execution and rial-tran		that initiated events	:			byears
9 Unknown 9 Unkn	3876	icate be physicia s the bu	dlcal	a Histal hernia				10 years
25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Yes 2 No 27. Manner of Death Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28c. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Yes 2 No	.O. Box	the death certify the attending ched for use as	ysician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 2 St. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death				
25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Yes 2 No 27. Manner of Death Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28c. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Yes 2 No	S, D	es that igned by be deta	by					
25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Yes 2 No 27. Manner of Death Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28c. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Yes 2 No	cord	w requi	leted		~ disease	-		
Work? State Control of the course of th	al Re	n: The la cate has r, page 2		97		autopsy performed? 1 ☐ Yes 2 2 N	prior to death?	completion of cause of
Work? State Control of the course of th	V.	sicier certif irecto	00	examiner?	Othor		0.500	**
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Majure, The Johns Hepkins Hospital, 600 North Wolfe Street, Baff, nore, Maryland, 21287 31. Date filed (Month, Day, Year)		ng Phy fter this meral d	\vdash	27. Manner of Death 28a. Date of Injury 28b. Tin	Attent 3 DOA 4 Nursing non			city)
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Majure, The Johns Hepkins Hospital, 600 North Wolfe Street, Baff, nore, Maryland, 21287 31. Date filed (Month, Day, Year)	/isio	Attendi	ficati	2 Accident investigation 3 Suicide 6 Could night be 28e. Place of Injury - At home, farm		28f. Location (Street	and Number or Ru	ıral Route Number,
David Majure, Medical Doctor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Majure, The Johns Hopkins Hospital, 600 North Wolfe Street, Baltinore, Maryland, 21287 31. Date filed (Month, Day, Year) 32 Pregistrar's Signature	ā	urs afte		4 normalize building, etc. (<i>specify</i>)				
David Majure, Medical Doctor RES-000 July 27, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Majure, The Johns Hopkins Hospital, 600 North Wolfe Street, Baltinore, Maryland, 21287 31. Date filed (Month, Day, Year) 32 Registrar's Signature		n 24 ho n 24 ho ne Fune	edica	(Check only 2 Medicel Examinar: On the basis of examination and	death occurred at the time, date and place, a or investigation, in my opinion, death occurre	and due to the cause and at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Majure, The Johns Hopkins Hospital, 600 North Wolfe Street, Baltinore, Maryland, 21287 31. Date filed (Month, Day, Year) 32 Registrar's Signature		To Tailting	E					-
David Majure, The Johns Hapkins Hospital, 600 North Wolfe Street, Baltinore, Maryland, 21287		(4)				July	1 27, 200	05
State 31. Date filed (Month, Day, Year) 32 Registrar's Signature		X		David Majure, The Johns Hopkins Horeital 600 A	ypo, mini) Postl Wolfe Street. Bellin	vorc . Maru	land 2	1287
Registrar AUG U 2 2005	8			31. Date filed (Month, Day, Year) 32 Registrar's Signature AUG 0 2 2005	Annalla B	7		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Month 00 AM **Physician** /Medical 4c. County of Death City, Town, or Location of Death **Examiner** 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign st hirthday **Funeral** 1 ☐ M 2 X F Vorth **Director** Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Heath and Mental Hygiene.
sent: If item 27 is marked other then "natural", or flems 23a or 28e-f show ury or other traumetic event, it is Macited Exp. illert and be inclifted at ury or other traumetic event, it is Macited Exp. illert and be inclifted at 1 Nes 2 No **Funeral Director** imore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give Year or Dates: Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🐒 No Specify. þ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working Elementary/Spcondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) HO1100 19b. Mailing Address (Street and Number or Rural Route Number 20b. Place of Disposition (Name of 20c. Method of Disposition 1 Burial 2 Cremation Department of importent: If any injury or once. 14 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/MedIcal 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9☐ Unknown 9 Ulnknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 1 🗀 Yes 246. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy has 1□ Yes To the Hospital or Attending Physician: Be 25. Was case eferred to medical 26. Place of Death (Check only Hospital: Other: 2 No 1 🗆 Inpatient 2 ER/Outpatient 4 🗀 Nursing Home 5 Residence 2 3□ DOA 6 Other (Specify) 1 Ye 28c. Injury at Work? completely filled in by the funeral 27. Manuer of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Certification: 1 Natural Injury 5 Pending 1 TYes 2 🗌 No investigation death. 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide after 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated. and due to the cause(s) ed (Month, Day, Year) certifie 29b. Signature who completed cause of death (frem 23a)

State Registrar 32 Registrar's Signature

		_	1 - State Ragistrar				tificat				ental Hy	Rag. 12.	005	25	139
	Physici /Medio	an	Decedent's Name (First, Middle, Last)		Irene	Mor	gan				2. Date of De Month	Day	200	r	ne of Death
	Examin	Ĭ	4a. Facility Name (If not institution, give: Union Memorial Hos	pital				Ba1t	Location	е			ounty of De		
	Funeral Director		5. Social Security Number 217-24-0439 Usual Residence of Decedent	/. Age] M 双汉 F	(In yrs. las	5 Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Di Dec. 2	rth ay, Year) 29,192	9 V	Birthplace (Si Country) irgin	ate or Foreign La
:	e Maryland a-f ehow	ctor	Maryland N/A		10c. City,	Town or Lo		1tim	ore						de City Limits Yes 2 ☐ No
:	ath with th	rai Dire	10e. Street and Number 1327 Clipper Heigh	ts Avenue			10f. Zip	Code	2121	1		10g. Citize	on of What U	Country? SA	
9000	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23a or 28a-f show other traumatic event, the Maritsal Examination and item of the maritsal and the	d by Funeral Director	11. Marital Status 1 Never Married 2/C/Married 3 Widowed 4 Divorced	12. Was Decedent £ Armed Forces? 1 □ Yes 及於 N If Yes, Give Year or Dates:		"	Vas Deced Yes, spec		spanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)		. Race - Ai Black, W pecify:	merican India hite, etc. White	
21215-0036	Z should be filed within 72 hours and Mental Hygienal Hygiens (is marked other than "natural", sumatic event, the Madical Exa	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12		+)	life. I	lent's Usua kind of wol DO NOT us Okkee	rk done d se retired	turina mos	t of worki	ng			ss/Industry State	
Maryland	ould be file I Mental Hy varked oth vatic event	To Be	17. Father's Name (First, Middle, Last) John Raymond D							Susi	(First, Middle e Iren	e Atk	ins		
≥ .	ss 1 and 2 sh of Health and item 27 (s m r other traum		19a. Informant's Name/Relationship (Ty Jesse Lee Morgan 20a. Method of Disposition	(Husba	nd)		Clip	per	Heigh	nts A	I Route Numb Venue Pate	Balt:	imore	, <i>Zip Cod</i> e) , MD 21 or Town, Sta	
	permit. Pages Department of I important: If ite any injury or o		XXBurial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License			dens	of Fa	ith	8	3/2/C	5 Funera 1timor	Fu1	lerto	n, MAr	yland
	ath certificate be executed attending physician and for use as the burial-transit for use as th	dical Examiner	23a. Part. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Myo	conseque A conseque	Do not enti-	The mode	e of dying fa	g, such as	cardiac o	r respiratory a	arrest,	Lyland	Approx	
.O. Box 6	The Taw requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 1 4 □ Pregnant at 9 □ Unknown	2 Fetal d	eath 3	Ectopic pro					23	d. Date of d	lelivery Day	Year
rds, P.	w requires that been signed to should be dete		Part II. Other significant conditions cor	ntributing to death bu	it not resulti	ing in the ur	nderlying ca	ause give	en in Part I		23e. Did 1	/ _		to the cause	of death? 4 □Unknown
		Completed									24a. Was auto perfo 1 - Yes		24b. Were prior t death 1 \(\sum Y\)	o completion ?	
ion of Vital	to the Hospital of Attending Physician: In within 24 hours after death. To the Funeral Director. After this certificate completely filled in by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner? 1 Yes	lospital: 1 Diffipatier 28a. Date of Injur (Month, Day		R/Outpatien 8b. Time of Injury		8c. Injury Work	or: 4 □ Nu	rsing Hor	(Check only one 5 The Residence Red. Describe	dence 6[pecify)	
Division	l o the Hospital of Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	. (Specify)						28f. Location (City or To	wn, State)			Number,
:	vithin 24 hours a vithin 24 hours a To the Funeral C completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physical Exeminates (Check only one) 1 Medical Exeminates (Chec	sician: To the best of ner: On the basis of and manner sta	examinatio	edge, death in and/or inv	estigation,	in my op	inion, dea	d place, a th occurre	and due to the ed at the time,	date and p	ace, and d	ue to the cau	
)	Z 1 8 0	_	29b. Signature and title of certifier	have	M.	D .	A	License T24	1389	46		JUL	30	nth, Day, Ye.	05
	Sta Registr		30. Name and address of person who co	ompleted cause of de	1) NIO		NE	mori	al	Hos	dic	B	Himo	AM 37

			1 - For State Registrar	State of Marylar	•	artment rtificate				giene) 5	25140
	Physici /Medic		Decedent's Name (First, Middle, Last)	Helen Doroth	y Murp	hy			2. Date of Dea Month July	-	2005	3. Time of Death 8:03 A. M
	Examin		4a. Fecility Name (If not institution, give s 117 Martha Road					Location of De Burnie	ath		y of Death	
	Funeral Director		5. Social Security Number 6. Sex		last birthday) Yrs.	If Under Months		If Under 24 H Hours Mi	n. (Month, Day	1	9. Birth	place (State or Foreign ntry)
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ly, Town or Lo	cation						10d. Inside City Limits
	e Mary Be-f sh	ctor	Maryland Anne Art	undel	Glen B	urnie						1 ☐ Yes 2 🖾 No
	as or 2	I Dire	10e. Street and Number 117 Martha Road	1		10f. Zip	Code 210)60		10g. Citizen of U . S		ntry?
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show amy finjury or other traumatic event, the Macdical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Deced If Yes, spec	lent of History Cubar	spanic Origin? n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Ra Bla	ce - Ameri ack, White, ity: Whi	etc.
2-0	72 hounders	eted	15. Decedent's Educ (Specify only highest grade		16a. Dece	kind of wor	k done d	uring most of w	rorking	16b. Kind of E	Business/In	dustry
21215-0036	within iene. than	Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5+)	life.	keepe	e retired,			Social	Secu	rity
Maryland 2	uld be filed Mental Hyg irked other	To Be C	17. Father's Name (First, Middle, Last) Stanis	laus Zebron					ame (First, Middle, Conica Myl	Maiden Suma		
ž	d d d d d d d d d d d d d d d d d d d		19a. Informant's Name/Relationship (Type Helen Koch / Da	_{pe, Print)} lughter		ng Address lartha			Rural Route Numbe en Burnie			,
re, l	permit. Pages 1 and 2 Department of Health Important: If item 27 i any injury or other tra ance.		20a. Method of Disposition	20b. F	Place of Dispo				Date	20c. Location		
Baltimore,	tment crant trant: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	G1	en Have	en Mer	n. Pa	ark 8/1				, Maryland
Ba	Depar Impor any in	5	21. Signature of Funeral Service License	n amerone h	//				Gonce Fun wav Balt			e, P.A. land 21225
d.	Physician		Immediate Cause (Final disease or condition	cations that caused the deal ne cause on each line.	th. Do not ent	er the mode	e of dying	g, such as card		rest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):							
	cuted nd ransit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	quence of):						10 m	
8760,	ate be executed hysicien and the burial-transit		resulting in death) Last	Due to (or as a consect.	quence of):							
.O. Box 68	that the death certifica ed by the attending ph detached for use as tt	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth = 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	al death 3	Ectopic pro					ate of deliver	ery Day Year
<u>α</u>	iw requires that s been signed b should be deta			enal u	Kcer	nderlying ca	ause give	in in Part I.				he cause of death?
Division of Vital Records,	The la ate has page 2	Completed	B/L	pneumon	rias				24a. Was a autop perfor	med2	Were auto prior to co death? 1 \(\subseteq \text{Yes}	opsy findings available impletion of cause of
Vita	ician: certific ector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:			. Othe		eath (Check only o			
ion of	Jing After fune	tlon: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time o Injury		8c. Injury Work	at	Home Resid			<i>y)</i>
Divis	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, str fy)	reet, factory	, office		28f. Location (S City or Tow	treet and Num n, State)	ber or Rura	al Route Number,
	Hospital or 24 hours afte Funeral Dire stely filled in b	edical	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examination	ner: On the basis of examina and manner stated.	ation and/or in	h annumed vestigation,	at the tim in my op	e, data and pla pinion, death oc	cal and dua to the c curred at the time, o	ausu(s) and m fate and place	anner as s , and due t	faled. o the cause(s)
	To the within ?	Med	29b. Signature and title of certifier	and manner stated.		290	. License	number		29d. Date sign	ed (Month,	Day, Year)
)	1		I shue					0544	13	07-	-29-	-2005
1	U		30. Name and address of person who co	mpleted cause of death (Itel — LL 360 (m 23a) (Type,	Print)	en	St.	Baltin	rore	mp	-2005 21225
	Sta Regist		31. Date filed (Mont), Day, Year) AUG 0 2. 2	32. Registrar's Sign	ature #	Societa	1					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Dav **Physician** Anna Marie Mitchell , 2005 AUGUST /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 215-09-5289 1 □ M 2 🔀 F 87 Yrs. Director July 24, 1918 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a. State 10h County 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examinar must be notified at 1 ☐ Yes 2 ☑ No Baltimore Co. Director Maryland Loch Raven 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6920 Donachie Road 21239 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2√ No Ď Specify. 3 X Widowed 4 □ Divorced White Completed the Mudical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Retail Store Clerk 8 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Is markad Charles L. Baver Anna Lieperth Pages 1 and 2 should nent of Health and Men 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any Injury or other trau once. 3220 Montebello Terr. Mrs. Patricia A. Lambdin /Niece Baltimore, MD 21214 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer Cem. 8/3/2005 Baltimore, MD 22. Name and Address of Facility 5305 Harford Road 🥍 Michael E. Canapp Baltimore, MD 21214 Leonard J. kuck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) **ACUTE MYOCARDIAL INFARCTION** /Medical Due to (or as a consequence of): Examiner PERIPHERAL VASCULAR DISEASE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner death certificate be executed burial-transit c.RECTIAL ALIEPDING that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physiclan Physician/Medical ISCHEMIA OF RIGHT LEG the asi IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown į Month Day 4☐Pregnant at time of death 5 Other (specify) the ģ been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2/02 No 3 ☐ Probably 4 ☐ Unknown 1 TYes page 2 should Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 25. Was case referred to medical director 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Yes 2 No Inpatient 2 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral ate of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident **Director**: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funeral Direct 4 | Homicide 100 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

100 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) , 灵也心了。 lehla M.O N August 0) D 41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. D. 7601 OSLER DRIVE TOWSON MARYLAND 21204 AUG 0 2 2005 Registrar

			For State Registrar	State of M	aryland / De	partme <i>ertifica</i>			ınd Mer		ene 3. N2 0 0	5 2	25142
	Physici	20	1. Decedent's Name (First, Middle, Last,							Date of Death Month	Day	Year	3. Time of Death
	Physici /Medic		Patricia J.	McGraw						July	31,	2005	2:50 a. ^M
	Examin	er	4a. Facility Name (If not institution, give Stella Maris			Т	imoni				4c. County o		ore Co.
	Funeral Director		5. Social Security Number 216-34-4816 Usual Residence of Decedent	7. Ag	ge (In yrs. last birtho	Month:	er 1 Year Days	If Under 2 Hours	Min.	Date of Birth (Month, Day,) 2b. 6,	^(ear) 1936	9. Birthpla Countr Mary	ace (State or Foreign Y) Tand
	ow ow		10a. State 10b. County		10c. City, Town o	r Location						100	d. Inside City Limits
	Mary a-f sh	ţ	Maryland N/A		Bal-	imore							1 Yes 2 □ No
	th the	Director	10e. Street and Number			10f. 2	ip Code			100	g. Citizen of W	hat Countr	y?
	23a 23a		7119 E. Baltimor	e Street				212	24		United	Stat	es
36	within 72 hours after death with the Maryland one. Than "naturel", or Items 23a or 28a-f show ite Medical Ever-iner man be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 💢 If Yes, Give	Ever in U.S. No	I3. Was Ded If Yes, sp 1 ☐ Yes		ispanic Orig in, Mexican Specify:	gin? (Specify , Puerto Rica	Yes or No- an, etc.)		- America , White, et Whit	tc.
8	hour		15. Decedent's Edu	Year or Dates:	16a D	ecedent's Us	ual Occurs	ation		11	6b. Kind of Bus		
15	nin 72 n "na Medis	Completed	(Specify only highest grad	e completed) College (1-4or		ive kind of ve. DO NOT	vork done d	during most	of working	,	ob. Italia of Bac	in lo sarin de	2011 9
212	giene giene	mo.	12 yrs.	College (1-40)	5+)	Hom	emake	r			0wn	Home	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene 1 feath and Mental Hygiene 1 feath or Items 23a or 28a-f show item 27 Is marked other than "naturel" or Items 23a or 28a-f show other treumatic event. It a Medical Ever first must be rediffed at	To Be C	17. Father's Name (First, Middle, Last) Oscar Stupri	ch					r's Name <i>(Fi</i> dred	irst, Middle, Ma	aiden Sumame Kougl	e)	
lan)	2 shoul and Ma Is mari		19a. Informant's Name/Relationship (Ty							oute Number, (Code)
	s 1 and 2 if Health item 27 I		Mr. John Malone /	Son		LO2 Du			ie Ba	ltimore	Mary Oc. Location - (21234
altimore,	permit. Pages: Department of H Important: If ite any injury or ot	1	1 X Burial 2 ☐ Cremation 3 ☐ F		20b. Place of D cemetery,			1		-		,	
Ħ	it. Pa intmer intant injury	1	* 4 □ Donation 5 □ Other (Specify)		Woodla		-	ss of Facility	3/4/200				aryland
Ba	permi Depa Impo any ir	. (21. Signature of Funeral Service Licens	Michael E	. Canapp				, Inc		5 Harfo timore		oad 21214
			23a. Part 1. Enter the disease, or compl	ications that cause	d the death. Do not								Approximate
1	Priysician		shock, or heart failure. List only o Immediate Cause (Final										Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		E CARDIOMS a consequence of)		Υ						
	Examiner		Sequentially list conditions,	b									
-	sit ad	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as	s a consequence of)								
_	and I-tran	Examin	that initiated events resulting in death) Last	Due to (or as	s a consequence of)								
8760,	loate be executed physician and s the burial-transit	aiE			3 d 3311334d31130 31)								
687	ficate physics the	edicai		3									
Вох	death certifi e attending I ad for use as	M/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		· 🗆 =					23d. Date	of delivery	y
	death e atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 XNo	4☐Pregnant a	2 ☐ Fetal death at time of death	3 ☐ Ectopic 5 ☐ Other (Mon	th D	Day Year
P.0	that the de ned by the a detached	hys	9 Unknown	9□ Unknown									
	es the igned be de	by F	Part II. Other significant conditions co	ntributing to death t	but not resulting in th	e underlying	cause give	en in Part I.					cause of death?
ord	w requires (been signe should be	ted								1 L Yes	2 LI No	3 Proba	bly 4X Unknown
Records,	0 S C/	Completed								24a. Was an autopsy	pi	rior to com	sy findings available pletion of cause of
-		S								perform 1 □ Yes 2	No 1	eath?	2□ No
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othi			heck only one			
of	Phys r this ral di	T. To	1 ☐ Yes 2 🛣 No 27. Manner of Death	1 ☐ Inpati			28c. Injun	4 □ Nu	rsing Home	5 Residen Describe hov	ce 6 COthe	r (Specify) ed	HOSPICE
lon	Attending in death. ector: After by the fune	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	a <i>ý Year)</i> Inju		28c. Injun Worl	k? Yes 2∐1			,,		
Division	el or Attendir after death. I Director: Al d in by the fu	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of In	njury - At home, farm	, street, fact	ory, office		28f.			r or Rural	Route Number,
Ö	tel or rs afte el Dir	Certification;	- I Tomolo	building, e	etc. (Specify)					City or Town,	Jiaie)		
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifying Phy (Check only one) 2 Medical Exemi	sician. To the best iner: On the basis of and manner s	t of my knowledge, of examination and/otated.	leath occurre or investigati	ed at the tin	ne, date and pinion, deat	d place, and th occurred a	due to the cau at the time, dat	use(s) and mar te and place, a	nner as sta nd due to t	ited. the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier			2	9c. Licens			29	d. Date signed	(Month, D	ay, Year)
				- /m_			D	4372	25		8/1	105	
	,)		30. Name and address of person who c	ompleted cause of	death (Item 23a) (T	pe, Print)				,	-	n	
	10		DR. TARIQ MAHMOO		DULANEY_VA	LLEY	RD.	TIMON	IUM, M	Ф_2109	3		
17	Sta	ate	31. Date filed (Month, Day, Year)		trar's Signature	porte	•						

2:50 a.m.

JULY 31, 2005

PATRICIA McGRAW

		Please	State of Ma					-		_		
		1 - For Stete Registrar	State of Ivid	ai yiai i		rtificate of		_	Reg. N	A A A	25113	
		Pacedent's Name (First, Middle, Last)	Λ1				2. Date of De	ath		3. Time of Death	
Physic /Medi		CARI JAN	68	1410	arti	U SF	۷.	July	D 2	ay Year	4:00 PM	
Exami		4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death				4c. County of Death		
		4764 Bonnie Brae Road				Pikesville				Baltimore		
Funeral		5. Social Security Number 6. Se	If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year)			rth ay, Yea	9. Birthplace (State or Foreign Country)					
Director		236-28-3604 Usual Residence of Decedent	81		Yrs.			12-25-	-1923	B Vi	rginia	
land ow		10a. State 10b. County 10c. City, Town or Location									10d. Inside City Limits	
Many P-1-sh	to	MD Baltimore	P	Pikesville						1 ☐ Yes 2X No		
th the	lrec	10e. Street and Number							itizen of What Co	ountry?		
death with the Maryland ms 23a or 28e-f show rmust be notified at	Funeral Director	4764 Bonnie Brae Road		21208				US	SA.			
r dea	ner	11. Marital Status 12. Was Decedent E Armed Forces?			S. 13.	Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			D~	14. Race - Ame Black, Whit		
s afte	by Fi	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ I If Yes, Give	☐ Yes 2X☐ No fYes, Give Year or Dates:		1 ☐ Yes XX No Specify:				Specify: African-American		
III & I & I & I S-0050 be filed within 72 hours after tal Hygiene. d other than "natural", or lite event, the Medical Examina		15. Decedent's Ed	16a Dece	Decedent's Usual Occupation 16t				b. Kind of Business/Industry				
n n n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			(Give kind of work done during most of working life. DO NOT use retired)				100.	so. Isale di Basiliosa Ilidastiy		
d with	E	12th	0+)	Merchant Seaman E				Eas	ast Coast Railroad			
be filed tal Hygid d other	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nan			me (First, Middle	, Maide	n Sumame)		
aryida should b ind Menti	2	Robert Martin				Mamie Klater						
2 short and lam.	١.,	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Tox								Zip Code)		
DESILITIONEY, INICITY IGNICA ZIZIO-UOSO PERMIT. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-1 show any injury or other treumatic event, the Medical Examinat must be notified at any ping.	1	Catherine Martin/Wife		20h B				Date Date				
Mges 1		20a. Method of Disposition 1 Derial 2X Cremation 3 December 20 Dec				osition (Name of matory or other pla	I			Location - City or	Town, State	
DELILITION permit. Pages Department of the Important: If its any injury or of ance.		'4 □Donation 5 □Other (Specify) South Carrol1 Crematory 8-1-05 21. Signature of Funeral Service Licenses 22. Name and Address of Facility.						Winfield, MD				
Depa Depa Impo any ir		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home 1.4. of Balto. Co. 9200 Liberty Rd, Randallstown, MD 21133								Balto. Co.		
		and Enter in different on the hock, or heart failure. List only of	thation that caused	the death			The state of the s			21133	Approximate	
700		shock, or heart failura. List only of the three times the course (Final	Food Denenta						tnterval Between Onset and Death			
Physician /Medical		disease or condition resulting in death)	a. Due to (or as			Juneal 16	1					
Examiner			Vonto	مه رودا	nr ar	R New Holy &	a atric	cl FiBr	71/4	NST.		
	Jer	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	Due to (or as a consequence of):								
cuted nd ransi	Examiner	liat initiated events	c. Csch	sun'c	Card	10 My Op	atly					
s be exe sician a		resulting in death) Last	^ `	or as a consequence of):								
ate b thysic	lical		d. 60001	MILLE	and	my (196	20					
I RECORDS, P.O. BOX 08/00, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE:	IF FEMALE: 23c. If yes, outcome of pregna					J				
DOX sath cer attendir for use	lan	in the past 12 months?	1 Live birth	2 Fetal death 3 Ectopic pregnancy				23d. Date of delivery Month Day Year				
the de	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown									
that hed by deta		Part II. Other significant conditions co	ntributing to death b	ut not resu	ulting in the u	inderlying cause giv	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?	
ecords, law requires t as been signe 2 should be	Completed by	iere Brovasculer accidents with MGH					ded	1 🗆	Yes	2 No 3 Probably 4 Unknown		
aw rec	olete	periologia, s	ore catheton 24a. Was autop perfor									
The It	E	11111				psy ormed?	rped? prior to completion of cause of death? 2☑No 1□Yes 2□No					
VITAL icien: T certificat ector, pa	0	25. Was case referred to medical		26. Place of Death (Check only one)								
T V nysic nis ce	To B	examiner? 1 ☐ Yes 2 No	nt 3 DOA Ott	3 □ DOA Other. 4 □ Nursing Home 5 🛪 Residence 6 □Other (Specify)								
ng Pl		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of lnjury at Work? 28d. Describe how injury occurred									
SIO tendi eath. tor: A	catl	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M 1 ☐ Yes 2 ☐ No								
ONVISION/OI Or Attending Phy atter death. Director: After this in by the funeral of	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office 28f. Location (City or To				Street a wn, Sta	Street and Number or Rural Route Number, vn, State)				
pitel burs a erel (
24 hc 24 hc Fun etely	edical	(Check only one)	iner: On the basis o and manner st	f examina	tion and/or in	in occurred at the ti ivestigation, in my	me, date and place opinion, death occ	e, and due to the urred at the time,	date a	s) and manner as nd place, and due	s stated. to the cause(s)	
Division/or vital records, F.O. box ob/ou, To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Me	≥ 29b. Signature and title of certifier 29c. License number 25c.							-	Od. Date signed (Month, Day, Year)		
/		I alan Letko	9.	1)37035 Qu					gust 1, 2005			
2		30. Name and address of person who c	ompleted cause of d	leath (Item	23а) (Туре,	Print)	1 2:	On at the	1	D		
1						4 Nd, Si	mte 205	1020cd 15.	EUN	, any b	NC 11133	
St	ate	31. Date fited (Month, Day, Year)	32. Regis	ers Signa -	ture	1						

			1 - For State Ragistrar	State of Man		epartment of H Certificate of I			iene 2005	25144	
			1. Decedent's Name (First, Middle, Last) 2. Date of Death							3. Time of Death	
	Physici /Medio		Anne McCaslin					July 37 2005 11:30 AM			
	Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of Death	1	4c. County of	Death	
			It Hernes 1		ree	Bal.	FIMOR.	e			
	Funeral		5. Social Security Number 6. S 213-20-7813	ex 7. Age (li ☐ M 2☐ F	n yrs. last birth	rs. If Under 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		Birthplace (State or Foreign Country)	
	Director		Usual Residence of Decedent	Λ	79 Y			11-11-1	.925	MD	
	yland Jow		10a. State 10b. County	10	Oc. City, Town	or Location				10d. Inside City Limits	
	a-fs	ctor	MD Anne Ar	unde1	Lint	hicum				1 ☐ Yes 2 ☑ No	
	ith the	Director	10e. Street and Number 10f. Zip Code						l0g. Citizen of Wha	at Country?	
	72 hours after death with the Maryland 72 hours after death with the Maryland naturel; or tems 23a or 28a-f show dical Examinat must be notified at	rai	706 Andover Road			2109			U.S.A.		
	er des Items	Funerai	11. Marital Status	12. Was Decedent Eve Armed Forces?	or in U.S.	 Was Decedent of His If Yes, specify Cuba 	ispanic Origin? (Spe ın, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Black,	American Indian, White, etc.	
36	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∐Yes 2X No If Yes, Give Year or Dates:		1 ☐ Yes 2\X\No	Specify:		Specify:	White	
ç	2 hou		15. Decedent's E	ducation	16a. [Decedent's Usual Occupa	ation		16b. Kind of Busir	ness/Industry	
7	Pin 7.	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)		Give kind of work done of life. DO NOT use retired	during most of workii f)	ng		,	
2	ge wil	Con	12	,	Hom	emaker			Own H	ome	
2	d oth	Be	17. Father's Name (First, Middle, Last,				18. Mother's Name	(First, Middle,	Maiden Sumame)		
2	y Mould in Men	T _o	Paul Semanowich				Mary Dac				
2	d 2 st th and 7 Is n treun		19a. Informant's Name/Relationship (Mr. Myron D. McC		19b. 704	Mailing Address (Street a Andover R				, , - ,	
ي -	1 and 1 And		20a. Method of Disposition		20b. Place of I	Disposition /Name of	1 0	-	MD 2109 20c. Location - Cit		
Ē	ages anf of tt: If it		1 X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif			crematory or other placend Vets. Ce					
Raltimore Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menalt Hygiene. Department of Health and Menalt Hygiene. Department of Health and Menalt Hygiene. Department of Health and Menalt Health and House 23a or 28a-1 show any injury or other treumatic event, the Medical Examination into the rediffed at once.		21. Signature of Funeral Service Licer		mar y ra				Crownsvi Funeral	Home	
ä	Deparimpoor any ir sonce.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home 1 Second Ave SW, Glen Burnie, MD 21061								
			23a. Part1. Enter the disease, or com shock, or neart failure. List only	plications that caused the	e death. Do no	ot enter the mode of dying	g, such as cardiac o	r respiratory arr	est,	Approximate Interval Between	
	Pnysician		Immediate Cause (Final disease or condition	10	Elen	NO CALCO DE CONTRACTO				Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a co						3000	
	LAdiminei	L	Sequentially list conditions, b							2 W/2	
7) 1	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of miury	Due to (or as a co	onsequence of):					
W Y	axecu and al-tra	xar	Cause (Disease of Injury that initiated events resulting in death) Last	c Due to (or as a co	onsequence of):					
68760	ificate be executed physician and as the burial-transit	edicai E		d							
68						-					
Box	death cert e attending od for use a	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		3 □Ectopic pregnancy			23d. Date of	f delivery	
7	e dear	sicia	in the past 12 months? 1 🗆 Yes 2 😿 No	4☐ Pregnant at tim		5 Other (specify)	-		Month	Day Year	
Д	w requires that the death certiful been signed by the attending should be detached for use a	Physician/M	9 Unknown	antibution to doub but a	ot socillies is		De la De al	00- 014-1			
2	signe	by	Part II. Other significant conditions of	ontributing to death out in	ot resulting in	the underlying cause give	en in Part I.		pacco use contribt es 2□No 3[te to the cause of death?	
· ~ .	requ	etec	- congest	ar Aca	J	- eur		-		. "	
No.	The law ate has b page 2 st	Completed	- FT	le sc	ens	9		24a. Was a autops perfori	in 24b. Wei sy prio med?, dea	re autopsy findings available r to completion of cause of th?	
\bigcirc	sicien: The lav certificate has rector, page 2	e Co	25. Was case referred to medical					1 ☐ Yes	1 D	Yes 2□No	
	Physicien: this certific ral director,	OB	examiner?	Hospital:	2 □ ER/Out	patient 3 DOA Othe	26. Place of Death er: 4 ☐ Nursing Hon			(Specific)	
2)		I	27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Ti	me of 28c. Injury	at 2		ow injury occurred	Specily)	
$\mathbb{A}^{C}($	Attending or death. ector: After by the fune	atio	DENatural 5 Pending 2 Accident investigation	1	111		Yes 2 □ No				
	or Att ther de irect	Certification:	3 Suicide 6 Could not b	28e. Place of Injury building, etc. (5	- At home, fare Specify)	n, street, factory, office	2	28f. Location (St City or Town		or Rural Route Number,	
~	pitel c		00 0 17 1	<u> </u>			N.				
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fi	edical	29a. Certifier Certifying Pr (Check only one) 2 Medical Exar	ysician: To the best of π niner: On the basis of ex- and manner stated	amination and	death occurred at the tim for investigation, in my op	ne, date and place, a pinion, death occurre	ind due to the ca ed at the time, d	ause(s) and manno ate and place, and	er as stated. due to the cause(s)	
	omple	Med	29b. Signature and title of certifier	O -		29c. License	number	2	9d. Date signed (A	Nonth, Day, Year)	
	F > F 0			1120		DI	5044		7/21.		
	σ_{r}		30. Name and address of person who	completed cause of death	h (Item 23a) (T	ype, Print)			12/168		
_	\	-	M REHMAN!	up 27/	Han	unmends !	ENGLa	O BA	IN M	2122)	
	Sta		31. Date filed (Month) Bay, Year) AUG 0 2 200	32 Registrar's	Signature	-					
	Registr	ar	1.30 0 % 200	RIBUR	D.	could					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#19b, perstate of Many land? Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. 12. 0 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MICHEL LILLIAN 1:30 P 30 2005 TULY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner NORTHWEST BALTIMORE HOSPITAL CENTER RANDALLSTOWN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/03/1916 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F 207-10-1630 89 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or Items 23s or 28s-f show traumatic event, the Medical Evantiner must be notified at MD BALTIMORE BALTIMORE 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 POMONA EAST #405 21208 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Evaria 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: WHITE 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SALES ROYAL FURNITURE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **ABSE** LOUIS H. MOLLIE LONG ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1043 19a. Informant's Name/Relationship (Type, Print) 4772 BEECHWOOD ROAD - ELLICOTT CITY, MD 21042 EDNA MOYER / NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 🎇 Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) OHEB SHALOM MEMORIAL 08/01/2005 REISTERSTOWN, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS. **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit ed by the attending physicien and detached for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2/2/No has this certificate 1 Yes 2 🗀 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Depatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After or Attending 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation efter death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year)

Tilly 20 2005 29b. Signature and title of certifie 30. Name and address Person who completed cause of death (Item 23a) (Type, Print) NOR 16 51 AVVER 11 HALLI JARISH 5401 OLD COUNT SOITEL ROAD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

2005

32 Registrar's Signature

		-	State of Maryland		artment of H			giene Neg. N2 0 0 5	5 2511.7
	Physicia		1. Decedent's Name (First, Middle, Last) ABRAHAM		MAZUR		2. Date of Dea Month		3. Time of Death ar 3:27 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	OOLI	4c. County of E	Death
	F		HOWARD COUNTY GENERAL HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. le	ast birthday)	COLUMB If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	HOWARI	Birthplace (State or Foreign
	Funeral Director		120-18-5610 1 ¹ Ø ^{M 2□ F} 81	Yrs.	Months Days	Hours Min.	8. Date of Birth Month, Day 06/08/I	924	NY NY
	laryland ahow		Usual Residence of Decedent 10a. State 10b. County 10c. City.	, Town or Loc	cation				10d. Inside City Limits
	Sa-fal	sctor		UMBIA					1 Yes 2 No
	3a or 2	Dire	10e. Street and Number 10109 WINDSTREAM DRIVE #3		10f. Zip Code 21044			10g. Citizen of Wha	t Country?
036	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or itams 23a or 28a-f ahow evant, the Medical Exacilier must be intillized at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S Amed Forces? 1 Never Married 2 Married In Never Married Size Press Give Year or Dates:	If	Vas Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🛱 No	ispanic Origin? (Spe in, Mexican, Puerto Specify:	cify Yes or No-	14. Race - A	American Indian, Vhite, etc. WHITE
21215-0036	natur	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	dent's Usual Occup kind of work done of DO NOT use retired	during most of worki	ing	16b. Kind of Busin	ess/Industry
212	e filed within al Hygiene. I othar than vant, the Ma	dwo	Elementary/Secondary (0-12) College (1-4or 5+) 5+		MS EXAMIN	,		SOCIAL SE	CURITY
and	I be filed ntal Hygi ed other evant, II	Be	17. Father's Name (First, Middle, Last) BENJAMIN	MAZU	ID	18. Mother's Name		Maiden Sumame) UNKNOWN	
Maryland	2 should be to and Mental I is marked or reumatic eva	7	19a. Informant's Name/Relationship (Type, Print)					r, City or Town, Sta	te, Zip Code)
	2 = 2 E		KATHLEEN MAZUR / WIFE		09 WINDST		E #3-C0	LUMBIA N	
more	0 0		1 N Burial 2 Cremation 3 Removal from State	emetery, cren	natory or other plac			REISTERST	
Baltimore,	permit. Page Department of Important; if any injury or once.		21. Signature of Funeral Service Licensee	22	. Name and Addre	ss of FacilitySOL	LEVINSO	N & BROS.	
			23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence)	uence of):	Anotis	SAS-			
	Examiner		Com	liac	ary t	hmis			
	nted I Insit	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ience of):	faller				
,00	be executed sician and burial-transit	I Examin	that initiated events resulting in death) Last Due to (or as a consequence of the consequ	ience of):	7011-12				
68760,	ficate b physic s the b	edical	d						
.O. Box (at the death certificate by the attending phys tached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)	,		23d. Date of Month	f delivery Day Year
Δ.	quires that t n signed by uld be deta	by	Part II. Other significant conditions contributing to death but not resu	ılting in the ur	nderlying cause giv	en in Part I.	23e. Did to	1_	te to the cause of death? Probably 4 Unknown
Il Records,	The law requires that sate has been signed by page 2 should be deta	Completed					24a. Was autop perfor 1 \sum Yes	rmed? prior	e autopsy findings available r to completion of cause of th? Yes 2 \(\sum \text{No}\)
Vital	Physician: T this certificat ral director, pa	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatien	nt 3□ DOA Oth	er: 4 Nursing Ho		ne) dence 6 □Other(Specify)
on of	ftei	h-		28b. Time of Injury	f 28c. Injur Wor	y at		now injury occurred	
Division	ial or Attanding s after death. al Director: Afte ad in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	reet, factory, office		28f. Location (S City or Tow		or Rural Route Number,
	To tha Hospital or / within 24 hours after To tha Funaral Direct completely filled in b	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my know and manner stated.	tion and too to.	and the second second	the transport and a matter of a contract of		det I lear and	dece he also servered at
	To the Within To the	Me	29b. Signature and title of certifier		29c. Licens	e number		29d. Date signed (A	fonth, Day, Year)
•	4		He Trala ms	220\ /7	021	2547		July 2	9,2000
	Q		30. Name and addre of person who completed cause of death (Item	23a) (Type,	LH+6	Patatent	Porkue	Colum	61 Maybul
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signal	iure	berte				Gode to the cause(s) Month, Day, Year) G 2000 Gry Mary full

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

cian	1- For Unpend Item 2 Registrar 1. Decedent's Name (First, Middle, Last) Ronald Miller				2. Date of Death Month	-	3. Time of Death
ical	4a. Facility Name (If not institution, give s	treat and number)	4h City Town	or Location of Death	JULY	30, 2005 4c. County of Dea	12:09P. M
iner	1309 RUSTIC AVE	(1881 and Humber)	ROSEDA			BALTIMOF	
l ,	5. Social Security Number 6. Sex 213 76 7833	N 00 5	thday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan. 16, 1		thplace (State or Foreign puntry) cyland
_	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimor	10c. City, Town	n or Location Rosedale				10d. Inside City Limits
Director	10e. Street and Number	•	10f. Zip Code	27	10	g. Citizen of What Co	
Funeral	1310 Rustic Avenue	2. Was Decedent Ever in U.S.	212		oifu Vac or No-	USA 14. Race - Ame	nican Indian
by	1 XNever Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cubi 1 ☐ Yes 2 ☒ No	Specify:	Rican, etc.)	Black, Whit	e, etc.
Completed	15. Decedent's Educ (Specify only highest grade	cation 16a. Completed) College (1-4or 5+)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of worki d)	ng	6b. Kind of Business	/Industry
Com	9	Conege (1-401 3+)	Laborer			Tree Servi	.ce
To Be	Junior Miller			18. Mother's Name Peggy A		aiden Sumame)	
	19a. Informant's Name/Relationship (Ty) Peggy Miller (Mothe		Mailing Address (Street 10 Rustic Av				
	20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ R	camato	f Disposition (Name of ry, crematory or other place	CB)		Oc. Location - City or	
	4 ☐ Donation 5 ☐ Other (Specify)	Bayvie	w Crematory		005 Ba	altimore,	Maryland
	21. Signature of Funeral Service License	Rouske	Bruzdzins 1407 Old E	ki Funeral	Home P.	A. ex, Md. 21	221
ical Examiner	disease or condition resulting in death) Sequentially list conditions, I amy, loading to minimulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	of):				
Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)	/		23d. Date of del Month	ivery Day Year
Š	Part II. Other significant conditions con	tributing to death but not resulting in	n the underlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Completed					24a. Was an autopsy performs 1 Yes 2	24b. Were au	itopsy findings available completion of cause of 2 \(\) No
o Be	25. Was case referred to medical examiner? 177 Yes 2 No	ospital: 1 Inpatient 2 ER/Ou	tpatient 3□ DOA Oth	er: 4 □ Nursing Hor	<i>(Check</i> on <i>ly</i> o <i>ne)</i> ne 5□ Residen		city) SCENE
Certification; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		ime of 28c. Injur		28d. Describe how		unk
110	3 ☐ Suicide 6 ♠ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify) Found at home			28f. Location (Stre City or Town, Rosedale,		ustic Ave.
Cert	29a. Certifier 1 Certifying Phys (Check only X Medical Examin	ician: To the best of my knowledge er: On the basis of examination and and manner stated.	e, death occurred at the tind d/or investigation, in my o	ne, date and place, a pinion, death occurre	and due to the cau and at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
	one) ZE				:104	d Data signed (Mant)	h One Varia
Medical Cert		N 14	29c. Licens	e number	290	d. Date signed (Monti	i, Day, Year)
edical	one) ZE	Melhely	un 0.c.			LY 31, 200	

			For 1 = State Registrar	State of M	aryland /	-	artment					giene Reg. 120 (15	2511.9
			Decedent's Name (First, Middle)	Last)							2. Date of Dea	ath		3. Time of Death
	Physici /Medio		HARRISON	NEWMAN	NU	TTER					JULY 29	Day 2005	Year	2:30 P M
	Examin		4a. Facility Name (If not institution,				4b. City,	Town, or	Location o	of Death		4c. County	of Death	1.5.50
			7650 Waterwood				G1en					Anne		del County
	Funeral		5. Social Security Number 234-70-4116	6. Sex 7. Ag	e (In yrs. last	birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt Month, Day June I	h Year)	9. Birthp	place (State or Foreign ntry) St Virginia
	Director		Usual Residence of Decedent		61	113.					June 1	8,1944	wes	st Virginia
	/land		10a. State 10b. County		10c. City, To	own or Lo	ocation						1	Od. Inside City Limits
	Mar.	tor	Maryland Anne A	rundel	Glen	Burr	nie							1 ☐ Yes 2 ☐ 1¶o
	or 28)ire	10e. Street and Number				10f. Zip					10g. Citizen of		ntry?
	ath w	la l	7650 Waterwood T					2106					.S.A.	
စ္တ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: If them 27 is marked other than "natural", or itams 23a or 28a-f show important: If them 27 is marked other than "natural", or itams 25a or 28a-f show any injury or other traumatic evant. It a Mindfull Examinar must be notified at once.	y Funeral Director	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Armed Forces? 1 Yes 2		1	Was Decedent Yes, special Total Yes 2		spanic Origon, Mexican Specify:	gin? (Spe 1, Puerto	acify Yes or No- Rican, etc.)	14. Rac Blac Specifi	ce - Americ ck, White,	etc.
Ö	hours ural',	q p	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:	1 40								W	hite
₹.	in 72	ojete	15. Decedent' (Specify only highest	grade completed)		oa. Deced Give life. l	dent's Usual kind of won DO NOT us	k done d e retired	ition <i>luring m</i> osi }	of worki	ing	16b. Kind of B	121U622/JUG	dustry
212	yiene.	E O	Elementary/Secondary (0-12) 12	College (1-4or s	5+)		inten					Excava	ating	Company
פ	be filed ntal Hyg of othe evant,	Be Completed by	17. Father's Name (First, Middle, L	ast)					18. Mothe	r's Name	(First, Middle,			
<u>ya</u>	should b ind Ments marked umatic e	To E	Harrison	J.		ıtter			Beu.				Hals	
_	and 2 sh saith and n 27 is m		19a. Informant's Name/Relationsh Victor D. Nutte		- 1	9b. Mailir 313	ng Address Glouc	(Street a	er Dr	ive (Glen Bu	r, City or Town, rnie, Ma	state, <i>Zip</i> ary1a	nd 21061
a a	Pages 1 anent of He nent of He int: if itam iny or othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		ceme	tery, cren	sition (Nam natory or oti	her place	1		Date	20c. Location -	•	
a ≣:	permit. F Departme Importan any injur		21. Signature of Fuperal Service L		Dayvi	22	Cremat Name and	Addres	e of Facility	8/2/(y _		Baltimon		
Ö	Per San Per Sa		the fi	Colline		Mic	Cully 204 Mo	-Pol	lynia! Rin Ro	k Fui bad]	neral Ho Pasadena	ome, P. <i>I</i> a. Marv	land	21122
			23a. Part#. Enter the disease, or of shock, or heart failure. List of	complications that caused only one cause on each li	the death. D	o not ent	er the mode	of dying	, such as	cardiac c	r respiratory an	est,	1	Approximate Interval Between
E	Pnysician		Immediate Cause (Final disease or condition	a En.	0577	56	Er	4.9	475	50	7-2			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequenc									
		-	Sequentially list conditions,	b. Due to (or as	a consequenc	e of):								
7	uted sussit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury											
8760, &	icate be executed physician and s the burial-transit	Еха	that initiated events resulting in death) Last	Due to (or as	a consequenc	e of):								
376	ate be nysicia he bu	dicai		d										
9	artifica ing pt e as t		IF FEMALE:											
Box	The law requires that the death certific tie has been signed by the attending p bage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 menths?	23c. If yes, outcome	2 Fetal dea		Ectopic pre					23d. Dat Mo	te of delive nth	ry Day Year
P.O.	that the de led by the a detached t	ysic	1 □ Yes 2 🗹 No 9 □ Unknown	4□Pregnant at 9□Unknown	time or death	5	Other (spe	спу)						
۵.	res that igned by be deta	by Ph	Part II. Other significant condition	s contributing to death b	ut not resulting	g in the ur	nderlying ca	use give	n in Part I.		23e. Did to	bacco use conti	ribute to th	e cause of death?
rds	w require: been sig should by										1 🗆 Y	es 2□No	3. Prob	ably 4 DUnknown
Division of Vital Records,	elawre hasbee ge 2sho	Completed									24a. Was a	an 24b. V	Vere autor	psy findings available inpletion of cause of
œ _		Com									perfor	med?	leath?	2⊡ No
<u>I</u> ta	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	12							(Check only or	200		
ot	ding Physician: The n. After this certificate h funeral director, page	5	1 Yes 2 No		nt 2 ER/0	Outpatien Time of		Other	r: 4 □ Nur		ne 5 Side)
o	ding F	tion	1 ☑Natural 5 ☐ Pending		Year)	Injury	M	lc. Injury Work'	at ? ′es 2∐N		.ou. Describe III	ow injury occurr	9u	
/ISI	or Attanding Physician: after death. Director: After this certifica in by the funeral director,	ifica	3 ☐ Suicide 6 ☐ Could no	ot be 28e. Place of Inju	ury - At home,	farm, stre	eet, factory,	office		2	28f. Location (Si	treet and Numb	er or Rura	l Route Number,
ā	s after s after af Direct	Certification:	4 Homicide	building, et	с. (Брөспу)						City or Town	n, State)		
	To tha Hospitel or Al within 24 hours after of To tha Funaral Direc completely filled in by	edicai	29a. Certifier 1 ☐ Certifying (Check only one)	Physician: To the best of xaminer: On the basis of and manner sta	examination a	ige, death and/or inv	occurred a	t the time in my opi	e, date and inion, deat	i place, a h occurre	and due to the co	ause(s) and ma ate and place, a	nner as sta and due to	ated. the cause(s)
	To the Ho within 24 To the Fu completel	Me	29b. Signature and title of certifier					License				9d. Date signed		
			•	12 M	0		>	05	150	06		08/	011	12005
	3		30. Name and address of person w	ho completed cause of d	eath (Item 23a) (Type, I	Print)	-		0	-	4 .		/
			21 Date filed (Marth Day York)	MD 30 Particular	72//	12/-	ee or	See	212	6//	smark.	12/	10-0	V 21225
	Sta Registr	te ar	31. Date filed (Month, Day, Year) AUG 0	2 2005	us a signature	· A	save)	,						1 2005

		•	FOI	partment of Health and Mertificate of Death	lental Hygier Reg. 1	2005 25150
I	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	/Medic Examin	al	Mary Parmlee 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		2005 4:30a M
	LAGITIII	CI	Future Care N.H.	Baltimore		NA
	Funeral Director		5. Social Security Number $246-30-7172$ 6. Sex $1 \square$ M $2 \square$ 7. Age (In yrs. last birthday 85 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 8-22-19	9. Birthplace (State or Foreign Country) N.C.
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Maryli -f sho	tor	Md. NA Ba	ltimore		1 AYes 2 □ No
	th the	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	ath wi		1001 Darley Ave.	21218		USA
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evaluation or other traumatic event, I'm Medical Evaluation or other traumatic event, I'm Medical Evaluation.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 □ Yes 2 ②No If Yes, Give Year or Dates:	8. Was Decedent of Hispanic Origin? (Sprif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
2	72 hou		15. Decedent's Education 16a. De (Specify only highest grade completed) (G.	edent's Usual Occupation we kind of work done during most of work	na 16b.	. Kind of Business/Industry
Maryland 21215-0036	within ne.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	. DO NOT use retired) eamstress	9	Varies
0	filed v Hygle other t	Be Co	17. Father's Name (First, Middle, Last)		(First, Middle, Maid	
/lan	wild be Mental Irked	To B	Mack Reynolds	UNKN		
/au	l 2 sho and l			iling Address <i>(Str</i> eet and Number or Rura Ol Darley Ave., Ba		
ē,	1 and Health 16m 2		20a Method of Disposition 20b. Place of Dis	position (Name of		Location - City or Town, State
altimore,	Pages ient of nt: If i		1 X Xurial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) King	ematory or other place) Mem. Park 8-3-	-05 R	andallstown, Md.
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility March F.H. East	Baltimo 1101 E.	re, Md. 21202 North Ave.
Г	*		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician (Madical	8 7	Immediate Cause (Final disease or condition resulting in death)			Onset and Death
Г	/Medical Examiner		Due to (or as a consequence of):	S ULCERS		
	ZMIN	ner	Sequentially list conditions, if any, leading to immediate causs. Either Undarphing Cause (Disease or injury			
	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	TIA		
8760,	icate be executed physician and s the burial-transit	al E	Due to (or as a consequence on).			
687	lificate g phys as the	edical	d.			
P.O. Box	Attending Physician: The law requires that the death certific sir death. sr death. ector: After this certificate has been signed by the attending to the funeral director, page 2 should be detached for use as	Physiclan/Me	1 Yes 2 No	B Ectopic pregnancy G Other (specify)		23d. Date of delivery Month Day Year
<u>Р</u>	that the ed by to detach	Phy	9 ☐ Unknown 9 ☐ U	underlying cause given in Part I.	23e. Did tobaco	to use contribute to the cause of death?
rds,	juires tha n signed lid be det	d by	PERIPHERAL VASULAR		1 ☐ Yes	2 No 3 Probably 4 Hriknown
COI	aw requir Is been si 2 should I	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Ä	The law ate has page 2 :	Com			performed	? death? _
Vita	Physician: Th r this certificate rral director, pag	Be	25. Was case referred to medical examiner? Hospital:	Othor	(Check only one)	
o	Phys er this eral dii	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	me 5 Residence 28d. Describe how in	6 ☐Other (Specify)
ion	anding lath.	atlo	1⊿Natural 5 ☐ Pending (Month, Day Year) Injur 2 ☐ Accident investigation	/ Work? M 1 ☐ Yes 2 ☐ No		
Division of Vital Records,	al or Attenos after death	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical (29a. Certifier (Check only one) Check only one) Check only one) Check only one) Check only one one one of the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cause ed at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	To the vithir comp	Me	29b. Sign fure and title of certifier	29c. License number	29d. I	Date signed (Month, Day, Year)
)	10		Portate) (ma	0005694		10C7 0 603
	4 '	- 11	30. Name and address of person who completed cause of death (Item 23a) (Type 23a). Date filed (Month, Day, 144 6 0 2 2 91 Register's Signature	e, Print)	BMF	inné po 421 1
	Sta		31. Date filed (Month, Day 1146 0 2 2085 Register's Signature	freeder		
	Regist	ar		ST.		

			For	State of Maryla				Mental Hygier	ne ne	•
			State Registrar		Cei	tificate o	f Death	Reg. I	2005	25151
Phy	siciai	n	Decedent's Name (First, Middle, Last		0				Day Yea	
100	ledica imine		JAMES)05 4a. Facility Name (If not institution, give		l'a-	4b. City, Town	, or Location of Dea		4c County of De	•
	· ·	g #	GILCHEIST C	ENTER			WSON		1.7	MORE
- Fune	_		5. Social Security Number 6. Se	x 7. Age (In yrs	s. last birthday) A Yrs.	If Under 1 Yea Months Day		(Month, Day, Yea	9. E	Birthplace (State or Foreign Country)
Direc	tor		220 - 05 - 8219 Usual Residence of Decedent		C) [113.			SEPT. 15, 1	915 BA	CTIMORE MD
ryland	.		10a. State 10b. County		City, Town or Lo	cation			-	10d. Inside City Limits
he Ma		0106	MD SAUTA	TORE	TAR	KUILL	E			1 Yes 2 No
death with the Maryland me 23a or 28a-f ehow		runeral Director	10e. Street and Number 8832 WALTHA	O RIVA		10f. Zip Code	21234	10g. 6	Citizen of What	Country?
36 after death w or Iteme 23a		Jera	11. Marital Status	12. Was Decedent Ever in	U.S. 13. V			Specify Yes or No-		mencan Indian,
36 after			1 Never Married 2 Married	Armed Forces? 1 XYes 2 □ No If Yes, Give		r Yes, specify Cl		rto Hican, etc.)	Black, WI	
21215-0036 of within 72 hours after giene.	1 7	ea ox	3 Widowed 4 □ Divorced	Year or Dates:		lent's Usual Occ			U	HITE
within 72 one then 'na	0	Completed	(Specify only highest grad		(Give	kind of work don DO NOT use reti	e during most of w	orking 166.	Kind of Busines	ss/Industry
21. ed wit ygiene ygiene			8		MEA	T PAC	KER	F	000	INDUSTRY
S be fill	á	ō	17. Father's Name (First, Middle, Last)	TR Sp			-	ame (First, Middle, Maid	,	,
Maryland Id 2 should be filt Ith and Mental Hy 27 Is marked oth	F	2	19a. Informant's Name/Relationship (7)	YEL SR.	19b. Mailin	a Address (Stre		HINE ST Rural Route Number, City	RANSKY	
- 10			EILEEN CLARKE /	DAUGHTER	2409		OS LANE	CHURCHU		
Baltimore, permit. Pages 1 a Department of Her mportant: If Item			20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F	20b.	Place of Dispos			Date 7 29c.	Location - City of	or Town, State
timor t. Pages rtment of l			4 □ Donation 5 □ Other (Specify)	Tr	72Kwao	o Ceme	TERY	2005 114	ekvicu	E, MD
Baltimo	once		21. Signature of Funeral Service Licens	98	22	Name and Add	ress of Facility	CHAPEL 88	co Han	mo 21234
10 TO		+	23a. Part1. Enter the disease, or compl	cations that caused the dea	th. Do not ente	er the mode of d	ying, such as cardia	ac or respiratory arrest,	CKVICCE,	Approximate
Physici	an		shock, or heart failure. List only or Immediate Cause (Final disease or condition	Se cause on each line.						Interval Between Onset and Death
/Medic Examin	cal		resulting in death)		quence of):					VA93
			Sequentially list conditions,	- Pireur	uncq					DAYS
uted A	Fyaminer		cause. Enter Underlying Cause (Disease or injury that initiated events	Chronic	Lilve	disea	10			years
O, Control of the con			resulting in death) Last	Due to (or as a conse	quence of):		-			
8760, cate be executed only sician and the burial-transit	le o	2		Asbesto	112					years
Records, P.O. Box 68760, The law requires that the death certificate be executed ten as been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medical		IF FEMALE:	3c. If yes, outcome of pregn	ancv					III.11
Geath death death death	100		23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		Ectopic pregnan Other (specify)	су		23d. Date of d Month	Day Year
that the de detached f	Syde	-	9 🗆 Unknown	9□ Unknown				_		
dS, F ires tha signed d be ded	É	֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	Part II. Other significant conditions cor	tributing to death but not re	sulting in the un	derlying cause g	liven in Part I.			to the cause of death?
Cord w require been si	Completed							1 Tes	//	robably 4 Unknown
The lav	, am							24a. Was an autopsy performed?	prior to death?	
f Vital F nysician: Th nis certificate director, pag	Be		25. Was case referred to medical				26. Place of De	1 Yes 2 N ath Check only one	o 1 ☐ Ye	s 2 No
Of V Physic this ce		2	TES PENO		ER/Outpatient	3□ DOA O	thor	Home 5 Residence	6 Other (Sp	ecity hospicy
ding P	<u>_</u>		27. Manner of ∄eath 1 Selatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju		28d. Describe how inj	ury occurred	
Division of Vital Records, to a Attending Physician: The law requires! after Geath. Director: After this certificate has been signs in by the funeral director, page 2 should be.	fleat		2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h	ome, farm, stre		Tyes 2 □No	28f. Location (Street a	and Number or F	Rural Route Number
Div tal or / s after al Dire	Certification:		4 Homicide determined	building, etc. (Speci	fy)	or, radioty, office	,	City or Town, Sta	te)	rara / route /vulitaer.
Hospit 4 hour Funar ely fille	edical (Check only /2 Medical Examit	ician: To the best of my kn	owledge, death	occurred at the	time, date and place	e, and due to the cause(s) and manner a	is stated.
Divisit To the Hospital or Attence within 24 hours after death To the Funaral Director: completely filled in by the	Med		one) 29b. Signature and little of certifier	and manner stated.	2		nse number		ate signed (Mon	
F ≥ F 8			Alran	Luis		1			-	
13	7		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type, P	Print)	,	Jowso - Towso	- 10	, 0 0
,			AARON Ch	orles ws	1009	N. CL	rovbes si	- 1000 za	n mo	21204
· 98604 _ 44	State istrar		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature Local	W				,

7/24/05 at

JAMES POYER

			For State Registrar	1 10430			id / Depa		Health and f Death	•	Hygien	-	25152
	Physici /Medi		1. Decedent's Name	. 11 /1	iri seau					2. Date of Month July	Death D	ay Year	3. Time of Death 2:37 PM
	Examir			-	ve street and number)		4b. City, Town	, or Location of De		4	c. County of Death	h
			Laure1 R 5. Social Security N	Regional		so lle um	la a h histh da . i	Laure		lro lo m		Prince G	
	Funeral Director		577-52-07 Usual Residence of	199	1□ M 2 X F	ge (iii yis. 8	o Yrs.	Months Day			Day, Year	9. Birth Con Gern	nplace (State or Foreign untry) many
	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other then "neturel", or items 23a or 28a-f show site event, it a Medical Examble mult be multiad at		10a. State	10b. County		10c. Cit	y, Town or La	cation					10d. Inside City Limits
	e Mar	ctor	MD	Prince G	eorge's	Lau	re1						1 XYes 2 ☐ No
	or 28	Director	10e. Street and Nur	nber				10f. Zip Code			10g. C	itizen of What Cou	untry?
	s 238			rel Lake	Court #2		0 10	2070		10 11 11		J.S.A.	
10	fter d	Funeral	11. Marital Status 1 □ Never Marrie	ed 2 Married	12. Was Deceden Armed Forces 1 Yes 2	?	.5.	f Yes, specify Cu	f Hispanic Origin? ıban, Mexican, Pu	erto Rican, etc.)	No-	 Race - Amer Black, White 	
9	el', o	þ	3 Xwidowed		If Yes, Give Year or Dates:			I□Yes 2XN	o Specify:			Specify: Wh	ite
2-0	72 ho	Completed	(Spec	15. Decedent's E	ducation ade completed)		16a. Deced	lent's Usual Occ	upation	vorkina	16b. l	Kind of Business/li	ndustry
121	hen "	mp	Elementary/Seco		College (1-4or	5+)			e during most of v red)	, c.m.ng	Nat	tional G	eographic
i B	filed v Hygie Ither t		12 17. Father's Name ((First. Middle, Last)		Key P	uncher	18 Mother's N	lame (First, Mide			
au	id be ental ked o	To Be	Fritz Elz		,					Koerber	die, ivialdel	n Sumame)	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of fleath and Mental Hygiene. Department of fleath and Mental Hygiene. Important: If Iem 27 is marked other then "neturel", or Items 23a or 28a-1 show any injury or other treametic event, Ite Medical Examinational De publicad an once.	-	19a. Informant's Na		Type, Print)		19b. Mailin	g Address (Stree			m <i>ber, City</i>	or Town, State, Zi	ip Code)
Ž	and 2 ealth a n 27 ls		Dorothy S	axty, Co	usin				rive, Laı				
ore	of He		20a. Method of Disp		Removal from State		lace of Dispo- emetery, cren	sition (Name of natory or other p	lace)	Date	20c. L	ocation - City or T	own, State
Ě	Pages Iment of I lant: If its jury or o		` 4 ☐ Donation	5 Other (Specif	(y)	For				3/04/05	Brei	ntwood, 1	laryland
Baltimore,	Department Department		21. Signature of Fur	neral Service Licer	nsee			. Name and Add				Funeral	
	40260		23a Part I Enter th	a pron -	plications that cause	d the death	34	01 Blad	ensburg	Road, B	rentw	rood, MD	20722 Approximate
	Medical Examiner	Examiner	Immediate Cause (I disease or condition resulting in death) Sequentially list conff any, leading to imcause. Enter Under Cause (Disease or it	ritialiure. List only Final n inditions, mediate rlying injury	one cause on each	Myoca s a consequ	rdial uence of):	Infarcti					Interval Between Onset and Death
	icate be executed physician and s the burial-transit	icai	that initiated events resulting in death) L	_	c Due to (or as	a consequ	uence of):						
.O. BOX	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 r 1 □ Yes 2 ☑ 9 □ Unknown	months?	23c. If yes, outcome 1 □ t.ive birth 4 □ Pregnant a 9 □ Unknown	2 🗌 Fetal	death 3	Ectopic pregnan Other (specify)	су			23d. Date of deliv Month	rery Day Year
cords, P	w requires that the de been signed by the s should be detached	þ	Part II. Other signifi	cant conditions c	contributing to death t	out not resu	ulting in the un	derlying cause g	iven in Part I.				the cause of death?
ř	stcien: The law re- certificate has bee irector, page 2 sho	Completed								24a. Wi au pe	as an itopsy informed?	prior to co	opsy findings available ompletion of cause of
	ien: rtifica	BeC	25. Was case referre	ed to medical					26. Place of D	l ∐ Yes eath <i>Check onl</i>		1 □ Yes	2 No
_	yd sign	ToE	examiner? 1 ☐ Yes 2 X M	٧o	Hospital: 1 Inpati	ent 2🏋	ER/Outpatient	3□ DOA O				6 □Other (Specia	fy)
Slon o	ending Physicien: hath. br: After this certifica he funeral director, p	ation:	 Manner of Death Matural Accident 	5 Pending investigation		iry ly Year)	28b. Time of Injury	28c. Inju	ury at ork? □ Yes 2 □ No	28d. Describ			
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral.	Certification:	3 🗍 Suicide 4 🔲 Homicide	6 Could not be determined	building, e	tc. (Specify	")	et, factory, office		City or 1	Fown, State		
;	the Hosp in 24 hou the Fune ipletely fil	ledical	one)	2 Medical Exan	ysician: To the best niner: On the basis o and manner st	it examinat	wledge, death ion and/or inv	estigation, in my	opinion, death oc	ce, and due to the curred at the time	ne cause(s e, date and) and manner as s d place, and due to	tated. o the cause(s)
	with To Com	Σ	29b. Signature and t	ille of certifier	1 He	e	2)		5323	5		te signed (Month,	Day, Year)
	20				completed cause of								
	V C)-		Darry1 Hi 31. Date filed (Month		13635 Ba1			, Laure	l, Maryla	and 2070	7		
	Sta Registra			0 2 2005	All solve		Lose						

DHMH 17 Rev 1/2001

CPM 05-05059 Ernest Pope

206	rope		For	State of Maryland /	Department of Health and M	Mental Hygie	ne
			1 - State Registrar		Certificate of Death	Reg.	NOODE SELES
	*		Decedent's Name (First, Middle,	Last)		2. Date of Death	S: Thine of Dealth
	Physic /Medi		E. rnest	· HODe			$^{\text{Pay}}$ $^{\text{Year}}$ $^{\text{Year}}$ $05:48 \text{ A}^{\text{M}}$
	Exami		4a. Facility Name (If not institution,	give street and number)	4b. City, Town, or Location of Death		4c. County of Death
Week.			3840 Elmora Ave	nue - rear	Baltimore		
	, Funeral		Social Security Number	. Sex 7. Age (In yrs. last i	Months Days Hours Min	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
	Director		12-56-9086	M 2□F 53	Yrs.	12-14	51 Maryland
	pur *		Usual Residence of Decedent 10a. State 10b. County	10c City To	own or Location		10d. Inside City Limits
	lany!	Į.	MI	P	- 11:		1 XYes 2 No
	with the Maryland a or 28a-f show Le natified at	ect	10e. Street and Number		10 70 Code	100	Citizen of What Country?
	with	ā	2051 / 100	Pala Nije	21213	Tog.	/ 1 C A
	ours after death w ai', or itema 23a Examinar must t	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp.	pecify Yes or No-	14. Race - American Indian,
(0	riter	Fun	1 Never Married 2 Marrie	Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
8	hours after tural, or ite al Examine	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ Yo Specify:		Specify: Plack
5-0036	2 8 3	Completed	15. Decedent's (Specify only highest	Education 16	ia. Decedent's Usual Occupation (Give kind of work done during most of work	sing 16b	b. Kind of Business/Industry
2	- 636	nple	Elementary her contary (0-12)	College (1-4or 5+)	life. DO NOT use retired)	T	
21	filed with Hygiene ther the		0 71 1		LODOFER	<i>†</i>	ENCE COMPANC
Ē	be fill	Be	17. Father's Name (First, Middle, La	st)	18. Mother's Nam	e (First, Middle, Maid	den Sumame)
3	nould be I Mental narked o	ဥ	Charles +	ope	217	abeth	teau
Maryland	is 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than other traumatic avent, Ir.s.M.		19a, Informant's Name/Relationship	(Tyur, Print) / (1, 1, 1)	9b. Mailing Addrass (Street and Number or Rui	ral Route Number, Ci	ity or Town, Stat <u>e Zio</u> Code)
	1 and 2 Health tem 27		20a. Method of Disposition	ope wye	of Disposition (Name of	Date 200	Location - City or Town, State
Baltimore,	in of h		Burial 2 Cremation 3	Removal from State	tery, crematory or other place)		
ij	t. Partmen		4 ☐ Donation 5 ☐ Other (Spe	. DU4 D	enot touth 8-		alto MD
Bal	permit. Pages Department of I Important: If it any injury or of once.		21. Signature of Funeral Service Lie	ensee Sud	Vousquare Gree	we true	serul Services
5-			22a Part Fotor the disease or or	emplications that caused the death. De	o not enter the mode of dying, such as cardiac	ld Bal	40 /MU 21217 Approximate
¥			shock, or heart failure. List or	ly one cause on each-line.	o not enter the mode of dying, fuch as cardiac	or respiratory arrest,	Interval Between Onset and Death
1	Physician / /Medical		disease or condition resulting in death)	a. ofisig	un vound of	Jean	
	Examiner			Due to (or as a consequênc	e of):		`
		<u>.</u>	Sequentially list conditions, if any, leading to immediate	bbue to (or as a consequenc	e of).		
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events				
o,	execting and and and and and and and and and and	Exa	resulting in death) Last	Due to (or as a consequenc	e of):		
8760,	cate be executed physician and the burial-transit	dical		d			
9			IF FEMALE:				
Вох	death certific e attending p ed for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea	th 3 Ectopic pregnancy		23d. Date of delivery
	0 0 0	sici	1 Yes 2 No	4☐Pregnant at time of death 9☐ Unknown	5 Other (specify)		Month Day Year
P.0	that the de led by the a detached f	Ph				OG- Biddeles	
Ś	9 5 9 9	by	Part II. Other significant conditions	contributing to death out not resulting	in the underlying cause given in Part I.		co use contribute to the cause of death? 2.20 No 3. Probably 4. Unknown
0		Completed				1 Tes	20 No 3 Probably 4 Unknown
ec	S 5 8	npl				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u>=</u>	ate pag	Cor				oerformed Yes 2	
ZE S	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital		h (Check only one)	
of	y o	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpatient 2 ER/C			
Division of Vital Records,	fter	Certification:	1 ☐Natural 5 ☐ Pending	(Month, Day Year)	Time of 28c. Injury at Work? M 1 Yes 2 Mio	28d. Describe how in	illury occurred
Si	Attending r death. ector: After by the fune	cat	2 Accident investigat 3 Syricide 6 Could not	be 390 Place of fairn. At home		296 Leasting (Street	t and Number or Rural Route Number.
Š	after Direction by	erti	4 Aomicide determine	building, etc. (Specify)	10 0 00 00 00 00 00 00 00 00 00 00 00 00	City or Town, St	(ate)
	Hospital 4 hours 2 Funeral lely filled	O E	29a. Certifier 1 Certifying	Physician: To the best of my knowled	ge, death occurred at the time, date and place,	38 40 G	more HVE
	24 h	edical	(Check only 2 Medical Ex	aminer: On the basis of examination a and manner stated.	and/or investigation, in my opinion, death occur	red at the time, da	and place, and due to the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Me	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, Day, Year)
	/ /	2	N/ 100	01111	O.C.M.E.		July 27, 2005
2	1		30. Name and address of person wh	o completed cause of death (Item 23a			741y 21, 2007
() (JIARON		Penn Street, Baltimo	re, Maryla	and 21201
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1		
ji.	Registi	ar	AUG 0 2	2005 Repense St.	Andi		

			1 - For State Registrar	State of Ma	ryland /	Depa		t of H	ealth a	and M	ental Hy	_	005	25151
J	Physicia /Medic		Decedent's Name (First, Middle, Last	Billy Al	len Pa	rker					2. Date of De Month JULY	Day	Year 7, 200	
)	Examin		4a. Facility Name (If not institution, give						Location	of Death		4c. C	County of Dea	th
	Funeral Director		St. AGNES HOSPIT 5. Social Security Number 6. Se 217 72 5223	7. Age	(In yrs. last b 48	oirthday) Yrs.	BAI If Under Months	TIM 1 Year Days	ORE If Under Hours	24 Hrs. Min.	8. Date of Bir (Month Da April	th Year) 1	•	thplace (State or Foreign ountry) aryland
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City, To									10d. Inside City Limits
	Be-f s	Director	Maryland Anne Ar	rundel	G1e	en Bu	urnie			- 		40 011		1 ☐ Yes 2 🛣 No
	death with the Maryland me 23a or 28a-f show r must be notified at		10e. Street and Number 1701 Kirk Road				10f. Zip	210	61			_	en of What C J.S.	ountry?
136	be filed within 72 hours after death with the Marylan Hygiene. de thygiene. de other than "naturel", or Items 23a or 28a-f show and, I're Madical Examinar man be notified an event, I're Madical Examinar man be notified an	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Education Armed Forces? 1 Yes 2 No lf Yes, Give Year or Dates:			Was Deced f Yes, spec 1 Pes 2				cify Yes or No Rican, etc.)		4. Race - Am Black, Whi Specify: W	te, etc.
ئے۔ آ	72 hou	eted	15. Decedent's Edi (Specify only highest grad		16	a. Deced	dent's Usua kind of wor DO NOT us	al Occupa rk done d	ition uring mos	t of working)g	16b. Kin	d of Business	/Industry
7	within 72 ene. then "na	Completed	Elementary/Secondary (0-12) 11th	College (1-4or 5+)		_{ро мот из} Supei					New	City (Optical
Maryland 21215-0036		To Be Co	17. Father's Name (First, Middle, Last)	Dunlap Pa	rker						(First, Middle,	, Maiden S		
Mary	s 1 and 2 should f Health and Men Item 27 is marke other treumatic		19a. Informant's Name/Relationship (7 Carol Parker / w	ype, Print) rife			ng Address Kirk				Route Numbe Burnie			
e,			20a. Method of Disposition	D	20b. Place cemet	of Dispo	sition (Nan	ne of ther place	9)	D	ate	20c. Loc	ation - City or	Town, State
Baltimore,	nit. Pages artment of ortant: If it injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	(Bayvi		Crema			8/2/2				Maryland
Бап	Departiment Important Important Important Important Inc.		21. Signature of Funeral Service Licen:	S00	10									ce, P.A. yland 21225
/60,	Physician /Medical Examiner Physician and	cal Examiner	23a. part 1. Enter the disease or compenshock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Atheroscie Due to (or as a c. Due to (or as a	consequence	o not entropy of or of):	er the mod	e of dying	, such as	cardiac or				Approximate Interval Between Onset and Death
O. Box 68	death certifical e attending phy ed for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal dea		Ectopic pr					23	3d. Date of de Month	olivery Day Year
٩,	ires that signed b I be deta	þ	Part II. Other significant conditions co	ontributing to death but	not resulting	in the u	nderlying c	ause give	n in Part	f.				o the cause of death?
Records,	The law requires that the sete has been signed by the page 2 should be detache	Completed									24a. Was auto perio	psy prmed?	24b. Were a prior to death?	utopsy findings available completion of cause of s 2 No
Vitai		BeC	25. Was case referred to medical examiner?	11				0,5		e of Death	(Check only	one)		
Division of \	ing Phys After this tuneral di	ition: To	1 Xes 2 No 27. Manner of Death 1 Xet and 5 Pending 2 Accident investigation	28a. Date of fnjury (Month, Day	t 2 □XER/0 7 28b Year)	Outpatier Time of Injury		28c. Injury Work	4 🗆 141	2	ne 5 Resi 28d. Describe			ecify)
Divisi	i Diffic	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuind building, etc.	ry - At home, (Specify)	farm, str	reet, factor	y, office		2		Street and wn, State)	Number or F	Rural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (29a. Certifier 1 Certifying Phr (Check only one) 2 Medical Exam	ysicien: To the best on niner: On the basis of and manner stat	my knowled examination a	lge, deat and/or in	h occurred vestigation	at the time, in my op	ne, date ar pinion, dea	nd place, a ath occurre	and due to the ed at the time,	cause(s) a date and p	and manner a place, and du	s stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier				290	c. License	number					nth, Day, Year)
)	7		Jashezy	realse	mo)		0.	C.M.	.Е.		JULY	28,20	005
	6		30. Name and address of person who of Tasha Z Gree	inhom m	D		111 1	PENN	STI	REET	,BALTI	MORI	E MAR	YLAND 2120
50	Sta Registi		31. Date filed (Month, Day, Year) AUG 0 2	2005 32 Hegistra	r's Signature	4 1	freel	9						

DHMH 17 Rev 1/2001

			1 - For Stete Registrar	State of Mary		partmen <i>ertificat</i>				Reg	ene 1. No 2 () ()	5 251	55
	Physic /Medi		Decedent's Name (First, Middle, Last)	Josephine	e Puppa	a				Date of Death Month July	Day Y	3. Time of 0	Death
	Examir		4a. Facility Name (If not institution, give s Howard C	treet and number) County General I	Hospital	4b. City,	Town, or	Location of	Death Columb	bia	4c. County of	Death Howard	
	Funeral Director	J.	215-09-4377	M 2 F 7. Age (Ir	yrs. last birthda Yrs.	Months	1 Year Days	If Under 24 Hours	Min.	Date of Birth (Month, Day, Y		Birthplace (State or Country) Maryland	Foreign
	Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland How		c. City, Town or	Location	EII	icott City				10d. Inside City	
	ath with the s 23a or 28 ust be nel	ral Director	10e. Street and Number 4650 Live Oak Court			10f. Zip		2104			g. Citizen of Wha	l	
980	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show deat Excoper rust by notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	 Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 	r in U.S. 1	3. Was Deceon If Yes, spectage 1 ☐ Yes		spanic Origi n, Mexican, Specify:	in? (Specify Puerto Rica	Yes or No- an, etc.)		American Indian, White, etc. White	
21215-0	within ane. than "	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(G	cedent's Usua ive kind of wo e. DO NOT us	rk done d se retired	turing most o	of working	16	Account	ness/Industry ing Dept. / Reta	ail
Maryland 21215-0036	be filed hal Hyg ad otha avant,	To Be C	17. Father's Name (First, Middle, Last) Walenty					18. Mother		Marya	anna Mach		
	1 and 2 Health a 8m 27 is thar tra		19a. Informant's Name/Relationship (Typ. Mrs. Marianne Schoeffiel 20a. Method of Disposition	d Daughter	19b. Ma 20b. Place of Dis cemetery, c	4650 Liv	e Oak	Court E		ty, Maryla		ate, Zip Code) y or Town, State	
Baltimore,	it. Page rtment o rtant: If njury or		1 Burial 2 Cremation 3 Ri 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	2		Rosary (22. Name an	Cemet	ery	08/04/2	2005	Dunda	alk, Maryland	
	Physician /Medical Examiner		23a. Part1. Enter the disease of complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	nentia	enter the mod	871 O		nbia Pike	Ellicott C	City, MD 21(Approximate Interval Between Onset and De	een eath #4
8760,	death certificate be executed e attending physician and ed for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co									
O. Box 6	death certifi e attending ed for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Da No 9 □ Unknown	Sc. If yes, outcome of p 1 Live birth 2 4 Pregnant at time 9 Unknown	Fetal death	3 □Ectopic pr 5 □ Other (sp					23d. Date of Month	f delivery Day Ye	ar
rds, P	sign sign d be	by	Part II. Dther significant conditions con	tributing to death but no	ot resulting in the	underlying c	ause give	on in Part I.		23e. Did toba	-	te to the cause of dea	
il Records,	The taw ate has b page 2 s	Completed								24a. Was an autopsy performe	prior deat	re autopsy findings av r to completion of cau th? Yes 2 No	railable use of
on of Vital	ling Physician After this certifi tuneral director	tlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 W No H. 27. Manner of Death 1 Matural 5 Pending investigation	ospital: 1 Vinpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpat 28b. Time lnjur	of 2	8c. Injury Work	at Nurs	sing Home 28d.		ce 6 Other (Specify)	
Division	o fre	Certification;	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury abuilding, etc. (S	At home, farm, Specify)	street, factory	r, office			Location (Stree City or Town, S		or Rural Route Numbe	ЭГ,
	To tha Hospital or At within 24 hours after or To tha Funaral Diract completely filled in by	edical	(Check only 2 Medicel Examin	icien: To the best of mer: On the basis of exa	y knowledge, de amination and/or	eath occurred investigation	at the tim , in my op	e, date and pinion, death	place, and o occurred a	due to the caust the time, date	se(s) and manne a and place, and	er as stated. due to the cause(s)	
	To t com	M	29b. Signature and title of certifier. 30. Name and address of person who col	npleted cause of death	ı (İtəm 23a) (Tve		. License	number D50	338	29d		Month, Day, Year)	5
) Sta	ite.	Poblete, Pio MD 1105	5 Little Patuxen	t Parkway;	Suite 205		umbia, M	1D 2104	4			
	Regist		AUG 0 2 20	105 Heren	J	bosto							

DHMH 17 Rev 1/2001

			State of N	faryland / Depa Cei	artment of H		, ,	ne N2005	25156
	Physic		Decedent's Name (First, Middle, Last) Joyce Diane Pharis		**		2. Date of Death	Day Year	3. Time of Death 11:05 A
	/Medi Exami		a. Facility Name (If not institution, give street and number	r)	4b. City, Town, o	r Location of Death	0d1y 27;	4c. County of Death	
	Jan M.	W.	Hospice of Baltimore Gilch					Baltimor	
	Funeral Director		6. Social Security Number 6. Sex 7. A 1	Age (In yrs. last birthday) 63 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye July 28,	9. Birth Cou. 1942 Mary	place (State or Foreign ntry) Land
			Jsual Residence of Decedent				5d1y 20;	1742 11419	
	arylan ehow	_	10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	ith the Marylar or 28a-1 ehow	Director	MD Baltimore Oe. Street and Number	Arbutus	101 7:- Onda		10-	Citizen et Marte et C	1 ☐ Yes 2 ₹ No
	death with the Maryland ms 23e or 28s-1 show	ä			10f. Zip Code			Citizen of What Cou	•
	death	Funeral	12. Was Deceder Armed Forces	t Ever in U.S. 13.	21227 Was Decedent of H	lispanic Origin? (Specan, Mexican, Puerto F		14. Race - Ameri	can Indian,
	36 safter		1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐	RNo .	1 ☐ Yes 2 ☒ No		iican, etc.)	Black, White,	
	15-0036 n 72 hours after death with the Maryla "nature!", or frems 23e or 28e1 e hou	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education		dent's Usual Occur	ation	166	. Kind of Business/In	
		piet	(Specify only highest grade completed)	(Give	kind of work done DO NOT use retired	ation during most of workin d)	g 100	. KIIO OI DUSHIOSSIII	dustry
	21.	Completed	10	Homen	naker			Own home	2
	and If be fill notal Hi	Be	7. Father's Name (First, Middle, Last) John Melvin Rottman			18. Mother's Name Lillian E			
	iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after to f Health and Mental Hygiene. If item 27 ie marked other then "naturel; or ite or other traumatic event, the Medical Examination	ဥ	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street	and Number or Rural			2 Code)
	Md 2 alth a alth a 27 is		Richard L. Pharis, Sr. / h						,
	Baltimore, permit. Pages t ar Department of Hea important: If item: any injury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo	sition (Name of natory or other place	Da	ate 20c	. Location - City or To	own, State
4	tim I. Pag tment tant: I		4 ☐ Denation 5 ☐ Other (Specify)	Meadowrid				kridge, Ma	-
105AM	Baltimore, Mispermit. Pages t and 2 Department of Health a Important: If item 27 is any injury or other trainness.		21. Signature of Funeral Service Litensee	1 872		ss of Facility Ambr		-	
05			23a. Part1. Enter the disease, or complical and that caus	ed the death. Do not ent		ur Spring ig, such as cardiac or		us, Maryla	Approximate Interval Between
-	Physician		shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition	line.	Corice	45			Onset and Death
	/Medical Examiner		resulting in death)	s a consequence of):					7
32	Examiner	-	Sequentially list conditions, b.	s a sunsuquenes of);					
8	A par Insu	Examiner	cause. Enter Underlying Cause (Disease or injury	e a soli esquel es ory.					
-	760, As be executed sicien and burial-transit		that initiated events c c Due to (or a	s a consequence of):					
_	thy at	dicai	d						
2	Box 6 eath certific attending p for use as	/Mec	F FEMALE: 23c. If yes, outcom	e of pregnancy				15	
2		hysiclan/Me	in the past 12 months?	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
ತ್ತ	that the d	hys	9 Unknown						
	က် အ ဂြီရ	by P	Part II. Other significant conditions contributing to death	but not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did tobacc	o use contribute to the	
5	ecord law requir as been si 2 should	ompieted		-			1 Ly Yes		oably 4 Unknown
g	The law ate has b	idmo					24a. Was an autopsy performed	prior to coi	psy findings available mpletion of cause of
Q :		O	25. Was case referred to medical		VA	26. Place of Death	Check only one	No 1 ☐ Yes	2 No
	of Vi	ToB	examiner? 1 Yes 2 No Hospital: 1 Inpat	ient 2 ER/Outpatien	t 3 DOA Oth	er: 4 Nursing Hom		6 ther (Specify	w - ospice
	Jn O ding Ph h. After th funeral	lon:	17. Manner of Death 1 Natural 5 ☐ Pending (Month, D	jury 28b. Time of ay Year) Injury	28c. Injun Worl	y at 28 k?	3d. Describe how in		1. 1
	ision death ctor:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of to	njury - At home, farm, stre		Yes 2 □No	3f. Location (Street	and Number or Rura	I Route Number
i	DIVI	Serti	4 Homicide determined building.	atc. (Specify)	and the second		City or Town, St.	ate)	Triodio Nambol,
	Div To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the besis and manner and manner series.	of examination and/or inv	occurred at the tin restigation, in my o	ne, date and place, ar pinion, death occurred	nd due to the cause d at the time, date a	e(s) and manner as st and place, and due to	ated. the cause(s)
_	To the To the Complex	Me	9b. Signature and title of certifier		29c. License			Date signed (Month,	
	1		1 / Anthon, Kil	y, und	02	5205	J	(729,0	1005
	り		0. Name and address of person who completed cause of	death (Item 23a) (Type,	Print)	5205 le 51.	P P-1.	1011 21	こうか
	Sta	te.		trar's Signature	to a	١, ١٥	1/0010	. Friq =1	
	Regist		AUG 0 2 2005	. D. Byon					

			1 - For State Registrar	State of Ma	aryland / Depa	artment <i>rtificate</i>			and M		giene Reg. NA	n 5	25157
	Physici		Decedent's Name (First, Middle, Las AUGUSTA	st)	2	POLTI	LOV	E		2. Date of Dea	30°	2005	3. Time of Death 4:50 P M
	/Medio Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, To	own, or	Location o	f Death		4c. Cou	nty of Death	<u> </u>
			MILFORD MANOR I				TIM				BAL	TIMORE	
	Funeral Director		5. Social Security Number 6. Sr 215-40-4698	ex 7. Ag □M 2 X □F	e (In yrs. last birthday) 93 Yrs.	If Under 1 Months	Year Days	Hours	Min.	8. Date of Birth (Month, Day 10/18/1	h () gar)	9. Birthp	lace (State or Foreign itry) MD
			Usual Residence of Decedent		75					10/10/1	1911		שויו
	arytan show	_	10a. State 10b. County N/A		10c. City, Town or Lo							1	Od. Inside City Limits
	the Mark	ecto	MD N/A		BALTIMO		'ada				10- Citi	of What Cour	1 Yes 2 □ No
	3a or	Funeral Director	3041 FALLSTAFF I	ROAD UNIT	605-D	10f. Zip C					-	S.A.	itry :
	death	nera	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Deceder	nt of His	spanic Orig	gin? (Sp	ecify Yes or No- Rican, etc.)		Race - Americ	
36	or lite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X I If Yes, Give	No.	1 ☐ Yes 2		Specify:	, i dollo	riioari, etc.)		Black, White, c <i>ify:</i> WHI	
Ö	72 hours after death with the Maryland naturel', or Items 23a or 28a-1 show Iteal Examble in util by molffied at	Completed by	3 🕅 Widowed 4 ☐ Divorced	Year or Dates:	16a. Dece	dent's Usual	Occupa	tion			16b. Kind of	f Business/Inc	dustry
215	within 72 ene. then "ns	plet	(Specify only highest gra	de completed)	(Give	kind of work DO NOT use	done di	urina most	of work	ing			,
2	e filed within al Hygiene. I other then '	Con		College (1-4or s	TEAC	HER						DUCATION	DN
Maryland 21215-0036	d b sent	To Be	17. Father's Name (First, Middle, Last) SAMUEL		HIL	LMAN		IDA	r's Nam	e (First, Middle,	Maiden Sum	name)	ENTON
lary	2 shoul and M is mar sumati	-	19a. Informant's Name/Relationship (7		19b. Maili	ng Address (nd Numbe		al Route Numbe			Code)
e, ≤	t and tealth om 27 ther tr		IRA ALBERT / SON	<u> </u>	20h Place of Dieno	seition (Nama	of	1		JNIT #60 Date			, MD 21209
Baltimore,	Pages nent of H int: If ite		1 🕅 Burial 2 □ Cremation 3 □		ANSTHE M	TIND A O'TH	er place	9)				on - City or To	
altin	그 돈 원 글 .		* 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen		HATIZ CHA	I I⁴I 2. Name and		jU		L/2005 _ LEVINS			
m	permi Depa Impo any ir		Acott /11-	atten	8	900 RE	IST	ERSTO	WN_F	ROAD - P	IKESV	ILLE,!	MD 21208
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	olications that caused one cause on each li	d the death. Do not en ne.	ter the mode	of dying	, such as	cardiac (or respiratory ar	rest,	100	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Termin	nal Aspir	ation)						Onser and Deam
	Examiner				a consequence of):	Dur	340	nin					
		ner	Sequentially list conditions, if any, leading to firm adiabase. Enter Underlying Cause (Disease or injury	Due to (or as	anonsaquence of	193	polo	yın					
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Deme									
8760,	icate be executed physician and s the burial-transit	al E		•	a consequence of):	nodmi	7 5						
687	death certificate ie attending phys ad for use as the	edic		. d		,,,,,,	1 3						
Вох	eath certific attending p for use as I	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		∃Ectopic preg	nancy					Date of delive	
	e deal the att	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐ Unknown		Other (spec						Month	Day Year
P.O.	res that the de igned by the a be detached t		Part II. Other significant conditions of	ontributing to death b	out not resulting in the u	nderlying cau	ise give	n in Part I.		23e. Did to	bacco use co	ontribute to th	e cause of death?
of Vital Records,	Se Po	ed by	Chronic Atria	1 Fibril	llation					1 🗆 Y	es 2□No	3 🗌 Prob	ably 4 Punknown
900	e taw requir has been si je 2 should t	Completed								24a. Was a		b. Were auto	psy findings available inpletion of cause of
Ä	The ate h page	Com								perfor		death?	
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe	-		n (Check only or			
	Phys or this eral di); To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Inju	ıry 28b. Time o		. Injury	at		me 5 ☐ Resid 28d. Describe h			′)
ion	Attending r death. sctor: Afte by the fune	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year) Injury	М	Work	? ′es 2 <u>□</u> 1	No				
Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined	286. Place of in	ury - At home, farm, st c. <i>(Specify)</i>	reet, factory, o	office			28f. Location (S City or Tow	treet and Nu n, State)	mber or Rura	l Route Number,
	the Hospitel or hin 24 hours afte the Funerel Dir npletely filled in I		29a. Certifier 1 Certifying Ph	vsician: To the best	of my knowledge, deat	h occurred at	the time	e date an	d place	and due to the o	ause(s) and	manner as st	ated
	n 24 h	edical	(Check only 2 Medical Examone)	niner: On the basis o and manner st	f examination and/or in	vestigation, ir	пту ор	inion, deat	h occur	ed at the time, o	date and plac	e, and due to	the cause(s)
	To the P within 24 To the F complete	M	29b. Signature and title of certifier	. / -				number	2/		_	ned (Month, I	
•	4		Maren & Bo					556	760		4114	31,2	005
(0		30. Name and address of person who icaren L. Bay: ++	completed cause of c	teath (Item 23a) (Type,	Print) Weet	Sul	te 20	ردر	Reister	rtown	MD	21136
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature				,			<i></i>	
	Registr	ar	AUG n 2 2	005	K 1	needes							

DHMH 17 Rev 1/2001

ORIGINAL

or Attending Physician: after death.
I Director: A in by the fu death. To the Hospital o within 24 hours aft To the Funeral DI

1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 X es 2 □ No Other: 4 Nursing Home 5 Residence 6 Dether (Specify) at Scene unk investigation 7-26-05 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Homper of Cural Pare Yumper . 4 - Homicide Glen Burnie, MD <u>Home</u> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie O.C.M.E. July 27, 2005 of person who complet se of death (Item 23a) (Type, Print) WUKE 111 Penn Street, Baltimore, Maryland 21201 1. Date filed (Month, Day, Year) Registrar's Signature

State Registrar

Medical

			For State	State of Maryla	-	ent of Health and	Mental Hyg	giene	
	_		1 State Registrar 1. Decedent's Name (First, Middle, La	acti	Certific	ate of Death	2. Date of Dea	Reg. No. 200	25159
	Physici /Medic		Dhylli5		Keill	¥	Month	26, 200°	5 630 PM
	Examir	er	4a. Facility Name (If not institution, give	ve street and number)	4b. (City, Town, or Location of De	ath I	46. County of De	ath
	Funeral Director		0 10 0 0 - 1	Sex 7. Age (In yrs	s. last birthday) If Unit Mon	nder 1 Year If Under 24 H ths Days Hours M		22, 1932 m	inthplace (State or Foreign Country)
	Maryland	tor	10a. State 10b. County	FOR F	City, Town or Location	+111			10d. Inside City Limits 1 ☐ Yes 2 No
	with the	I Director	10e. Street and Number	m:11 p)	10f.	Zip Code		10g. Citizen of What C	Country?
36	be illed within 72 hours after death with the Maryland ital Hygiene. od other then "netural", or Iteme 23a or 28e-f show event, the Medical Examiner must be notified at	y Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in I Armed Forces? 1 Yes 2 No	1	ecedent of Hispanic Origin? specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh	
8	72 hours netural', lical Ex	ted by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E	Year or Dates:	16a. Decedent's l	Usual Occupation		16b. Kind of Busines	s/Industry
21215-0036	within 73 ene. then "n	Completed	(Specify only highest grant Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of life. DO NO	f work done during most of v T use retired)	vorking	Falterte	ioment
	e filed within al Hygiene. other then vent, the Ma	0	17. Father's Name (First, Middle, Last	ı)	01	NGEK 18. Mother's N	lame (First, Middle,	Maiden Sumame)	Cl
Maryland	2 should be and Mental Is marked ceumatic even	To B	George r	nayGers	5	Cat	nerine	Royc	rolt
	s 1 and 2 should if Health and Mer item 27 is marke other treumatic		19a. Informant's N. m. Relationship (Reilly	19b. Mailing Addi	rss (Stree and Number or	Rural Route Number	7, City or Town, State, CICS: 20c. Location - City o	-Hill 121050
Baltimore	0 0		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	☐Removal from State	cemetery, crematory ONSFUNETA	or other place)	Y29.2005	Forest Hi	II, MD
Balt	permit. Pag Department Importent: I any Injury o once.		21. Jign Luca of Fundral Service Lices	n	22. Name	e and Addr ss of Facility	Jans fune Forest	eral drape	010-
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.			iac or respiratory arr	est,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a conse	etastas e	25			inonths
	Examiner	-e	Sequentially list conditions, if any, leading to immediate	b. Lympho Due to (or as a conse					months
X	ecuted and transit	Examiner	cause. Litter Universifing Cause (Disease or injury that initiated events resulting in death) Last	с.					
8760,	death certificate be executed e attending physician and d for use as the burial-transit		in South, East	Due to (or as a conse	equence of):				
9	ertifica ling ph	Med	IF FEMALE:						
.O. Box		Physiclan/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 □Ectopi	ic pregnancy (specify)		23d. Date of de Month	livery Day Year
Δ.	The law requires that the site has been signed by the bage 2 should be detache	by	Part II. Other significant conditions of	contributing to death but not re	sulting in the underlying	ng cause given in Part I.		pacco use contribute t	o the cause of death?
of Vital Records,	has bee	Completed					24a. Was a autops	v prior to	utopsy findings available completion of cause of
Ta E	Physicien: The la r this certificate has ral director, page 2	e Cor	25. Was case referred to medical			OG Bloss of D	perform	No 1 Yes	s 2□ No
Ž	Physicien: r this certifica ral director, p	To B	examiner? 1 🗆 Yes 2 🕰 No	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3☐	DOA Other: 4 Nursing	. 4	e) ance 6 □Other (Spe	ecify)
o uoi	l or Attending Phatter death. Director: After the	Certification;	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe ho	ow injury occurred	
Division	al or Atter after de Director d in by the	ertific	3 Suicide 6 Could not b 4 Homicide determined		home, farm, street, fac ify)	ctory, office	28f. Location (St. City or Town	reet and Number or R n, State)	ural Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical C	29a. Certifier Check only one) The Certifying Ph	hysicien: To the best of my kn miner: On the basis of examin- and manner stated.	nowledge, death occur nation and/or investigat	red at the time, date and pla tion, in my opinion, death oc	ce, and due to the ca curred at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	0		29c. License number	25	9d. Date signed (Mon	th, Day, Year)
	7.		I (Julie)	my mp		D53186		1-29-0	5
	10		30. Name and address of person who TullE Tinn			ncPhail Rd	B-1 A	ir MO &	1014
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	and continued		10 00	/
	Registr	ar	ALIG n 2 2005	Menelin &	poule				

DHMH 17 Rev 1/2001

			1 - For State Registrar	State o	f Maryland / [artment <i>tificate</i>			and M	-	giene Reg. N2	005	25	160
	Dhysiai		1. Decedent's Name (First, Middle,	Last)							2. Date of De				ime of Death
	Physici /Medic		Ida F.								July	27,	2005	10	:09 P M
	Examir	ier	4a. Facility Name (If not institution, 20 Heartwood Co	ourt			4b. City, T Parl	kvi1	le				Balti		
	Funeral Director		5. Social Security Number 216-22-6624 Usual Residence of Decedent	5. Sex 1 □ M 2 🂢 F	7. Age (In yrs. last bii 85	rthday) Yrs.	If Under 1 Months	Days	If Under : Hours	Min.	8. Date of Bir (Month, Da March	29,19	9. 6	Birthplace (S Country) Mary I	State or Foreign and
	land ow		10a. State 10b. County		10c. City, Tow	n or Lo	cation							10d. Ins	side City Limits
	Many a-f sh	to	Maryland Baltim	ore	P	ark	ville							10]Yes 2∭ No
	th the	Director	10e. Street and Number				10f. Zip 0	Code				10g. Citiz	en of What	Country?	
	ath w		20 Heartwood C			.,		212	34				USA		
36	within 72 hours after death with the Maryland ane. than "natural", or Itams 23a or 28a-f show is Mudical Exemirer mast be millied at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3√□ Widowed 4 □ Divorced	Armed Fo	2 MNo e	'	Vas Decede f Yes, specif I □ Yes 2]	y Cubai	spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto l	cify Yes or No Rican, etc.)		4. Race - Ar Black, Wi Specify: V	nite, etc.	ian,
21215-0036	2 hou		15. Decedent's	Education		. Deced	lent's Usual	Occupa	tion				d of Busines		
215	ba filed within 72 ha Ital Hygiene. d othar than "natu avent, Ire Mudical	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1	-4or 5+)	(Give life. L	kind of work OO NOT use	done a retired,	luring most)	t of workii	ng			,	
2	filed within Hygiene. othar than rent, the M	Con	6			Нс	memak	er					wn Hon	ie	
Maryland		Be	17. Father's Name (First, Middle, L.	ast)					18. Mothe		(First, Middle,		Sumame)		
<u>S</u>	s 1 and 2 should ba f Health and Mental itam 27 is marked o other traumatic ave	ဥ	Irvine Henry 19a. Informant's Name/Relationshi	a /Tuna Briat	106	A 4 - 11:-		200-01			La Shue		T 0::		
₹ S	S S S S			, , , , ,							Route Number	-			
	os 1 and 30 Health itam 27 rothar tr		John D. Robinson 20a. Method of Disposition		20b. Place of	f Dispo	sition (Name	a of			ate		ation - City		
m _o m			1 Burial 2 Cremation 3		State Metro	-	matory or oth		´ 1	07/28	8/05	Rol+-	imore,	Mozel	Lond
Baltimore,	구타라는		21 Signature of Euneral Service In	-	TREETO					y) (M	Dall.	more,	rially	Tand
m	Departing any ir sonce.		Thomas Grego	or		2	remati 99 Fre	1on eder	Socie ick H	ety (Road	of Mary Baltim	ore.	, Inc. Marvl	and 2	1228
П		v	23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that cannot one cause on e	aused the death. Do i	not ente	er the mode	of dying	, such as	cardiac o	r respiratory ar	rest,	<u>-</u>	Appro	ximate al Between
	Pnysician	0.79	Immediate Cause (Final disease or condition	. 2	EHYDRA	110.	N.							Onse	t and Death
	/Medical Examiner		resulting in death)		or as a consequence										/-
		<u></u>	Sequentially list conditions,	b	or as a consequence		AR		Aca	100	ル ケ				YEMA
	nted Insit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	017.								J	
, ,	be exacuted sician and burial-transit	Еха	that initiated events resulting in death) Last	c Due to (or as a consequence	of):							-		
8760,	cate be ex physician the buria	dicai		d											
99	the death cartificate y the attending phys tched for use as the	Medi	IF FEMALE:												
Вох	eath cartific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?		come of pregnancy rth 2 - Fetal death	3□	Ectopic preg	gnancy				23	3d. Date of d		Vans
0	the a	/sici	1 Yes 2 No	4□Pregna 9□ Unkno	ant at time of death wn	5 🗀	Other (spec	cify)					MOHILI	Day	Year
0	that the dead by the detached		Part II. Other significant condition	s contributing to de	ath but not resulting in	n the ur	deriving cau	ıse give	n in Part I.		23e. Did to	bacco us	e contribute	to the caus	e of death?
Records,	requires that een signed b nould be deta	d by		, and the second	J.		, , ,	,			1 🗆 Y	es a	[No 3□	Probably	4 Unknown
00	> 0 70	Completed									24a. Was	an	24b Were	autonsy fine	dings available
Re	rhe age	E O									autop perfor	med?	prior to death	completio	n of cause of
	sician: certifica rector, p	a	25. Was case referred to medical		.				26. Place	of Death	1 ☐ Yes	2 No	1 🗆 Y €	s 2□No	
\	S S	To B	examiner? 1 □ Yes 2 X No	Hospital: 1 🗆 II	npatient 2 ER/Ou	tpatien	3 □ DOA	Othe			ne 5 Resid		□Other (Sp	ecify)	
			27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of (Montal)		Time of njury	280	c. Injury Work	at		8d. Describe h				
Sio	Attanding r death. actor: After by the fune	cati	2 Accident investiga 3 Suicide 6 Could no	t bo			М		es 2 🗆 N						
=	in Line	Certification:	4 Homicide determin	ad 286. Place	of Injury - At home, fa ig, etc. (Specify)	ırm, stre	et, factory, o	office		2	8f. Location (S City or Tow		Number or i	Rural Route	Number,
_	Hospital		29a. Certifier 1 27 Certifying	Physician: To the	best of my knowledge	death	occurred at	the time	a data and	t place a	nd due to the	21150/5/ 2	nd manner	ac stated	
	To the Hospital or Attanowithin 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Ex	(aminer: On the ba	sis of examination and er stated.	d/or inv	estigation, in	n my op	inion, deat	h occurre	d at the time,	date and p	lace, and di	ue to the ca	use(s)
	To th Withir Comp	Me	29b. Signature and title of certifier				29c. I	License	number			29d. Date	signed (Moi	nth, Day, Ye	ear)
	1) 2	32er	o mo			DY	048	0	4	July	28	, 20	05
	b		30. Name and address of person w	no completed cause	of death (Item 23a) ((Type, I	Print)	60	2 /	sele	in R	al.			
			FERNANDS	FERM	20,000		B	0.17	10,	190	2/2	36			
H	Sta Registr		31. Date filed (Month, Day, Year) AUG 0	2 2005	best of my knowledge sis of examination and er stated. of death (Item 23a) (construction of the state of t		parte	P							

State of Maryland / Department of Health and Mental Hygiene For Stete Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Year **Physician** WALTER E. RIDGEWAY, JR. AUGUST 1,2005 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Saint Joseph Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 5 Social Security Number 6. Sex Days **Funeral** Months Min 1 XM 2 □ F 82 10/2/1922 ARKAŃSAS Director 265-26-7998 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a State 10b. County or 28a-f show ust be notified at 1 ☐ Yes 2 XNo Completed by Funeral Director TOWSON BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21286 8534 PLEASANT PLAINS ROAD Items 23g filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☑ No Specify: 3 X Widowed 4 □ Divorced "netural", 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) NUCLEAR CONSTRUCTION Hygiene. 3 YEARS (1-4or 5+) Elementary/Secondary (0-12) ENGINEER other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be fill iment of Health and Mental H tent; If item 27 Is marked others. DOROTHY DIXON WALTER E. RIDGEWAY, SR. ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10831 SHERWOOD HILL RD. OWINGS MILLS, MD 21117 WALTER E. RIDGEWAY, III/SON other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H
Importent: If ite
any injury or ot
once. 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State METRO CREMATORY, INC. 8/3/2005 CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a CHRONIC OBSTRUCTIVE LUNG DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** CONGESTIVE HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed . LUNG CANCER that initiated events resulting in death) Last Due to (or as a consequence of): burial-Box 68760. physician Physician/Medical the IF FEMALE: use a 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy perform 1 Yes Division of Vital To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Hospital: Inpatient 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 70 this 27. Manner of Death Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ate of Injury After t Certification: 5 Pending investigation 2 No after death. 1 Yes 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2005 ehto. M.C 41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACINDER MEHTA M. D. 76.01 OSLER DRIVE TOWSON MARYLAND 21204 Registrar

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of I			giene	5 25162
	Physic		Decedent's Name (First, Middle, Las Ruth	Rieger				2. Date of De Month July	aath	3. Time of Death ar 4:57 p M
	/Medi Examir		4a. Facility Name (If not institution, give Gilchrist Cen	,		4b. City, Town,	or Location of Do		4c. County of D	eath
	FuneralDirector		5. Social Security Number 6. Social Security Number 1 429-03-3170 1 Usual Residence of Decedent	7. Age	(In yrs. last birthday, 92 Yrs.	Months Days		nirs. 8. Date of Bir (Month, Da Vovember	^{rth} 24, 1912 Arl	Birthplace (State or Foreign Country) <ansas< b=""></ansas<>
	the Maryland 28a-f show notified at	tor	10a. State 10b. County MD Baltir	nore	10c. City, Town or L					10d. Inside City Limits 1 ☐ Yes 2 No
	vith the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	eath v	Funeral	608 Goucher Blvo	12. Was Decedent E	ever in U.S. 13	Was Decedent of		(Specify Yes or No	U.S.A.	merican Indian,
920	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Items 23a or 28a-f show event. The Madiral Expluiter must be multiled at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	0	Il Yes, specify Cut	an, Mexican, Pu	erto Rican, etc.)	Black, W	/hite, etc.
2-0	72 ho	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occu	during most of	working	16b. Kind of Busine	
21215-0036	filed within Hygiene. other than other, the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	ce Manage			Insuranc	e Agency
	al Hyg	Be C	17. Father's Name (First, Middle, Last)					Name (First, Middle	, Maiden Surname)	e rigeriey
Maryland	2 should be in and Mental I is marked or raumatic eve	7	Benjamin Ma 19a. Informant's Name/Relationship (7)		Hooten		Effie			
	D =		Joan Gresham-nied						er, City or Town, Stat Springs A	
Baltimore,	8°= 5		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		20b. Place of Dispo	osition (Name of matory or other pla	ice)	Date	20c. Location - City	
Balti	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service Licen	الناانة والمنافعة المنافعة ا		2. Name and Addre	ess of Facility Ro	uck Tawson F n, MD 21204	uneral Home,	, Inc.
	Physician /Medical	75-17-	23a. Part1. Enter the disease, or comp shock, or heart lailure. List only of Immediate Cause (Final disease or condition resulting in death)	aCoro-	θ.	ter the mode of dy	ng, such as card		rrest,	Approximate Interval Between Onset and Death
8760,	cate be executed by sician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b	consequence of):					
.O. Box 6	requires that the death certifics een signed by the attending pt hould be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 1% months? 1 Yes 2 Who 9 Unknown	23c. If yes, outcome of 1 □ Live birth 24 □ Pregnant at 19 □ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of Month	delivery Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions of	ntributing to death bu	t not resulting in the u	nderlying cause gr	ven in Part I.	23e. Did to		e to the cause of death? Probably 4 Unknown
Division of Vítal Records	The law ate has b page 2 s	Completed	Of Wasserstein to					24a. Was autor perfo 1 🗌 Yes		autopsy findings available to completion of cause of ? es 2 \(\text{No} \)
<u>¥</u>		o Be	25. Was case referred to medicał examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatier	it 2 ☐ ER/Outpatier	nt 3□ DOA Ott	200	Death Check only o		10 48 01
ion of	ng Iter Ine	atlon: T	27. Manner of Death 1 Statural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b. Time o	l 28c. Inju Wo			dence 6 Other (S	pecify) MOSP (C
Divis	Ne Hospital or Attendi 124 hours after death. Ne Funeral Director: A lietely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc.	ry - At home, larm, str (Specify)	eet, lactory, office		281. Location (S City or Tov	Street and Number or wn, State)	Rural Route Number,
	To the Hospital or At within 24 hours after o To the Funeral Direct completely filled in by	Medical	29a. Certifier Check only 2 Medical Exam	rsician: To the best o iner: On the basis of and manner stat	examination and/or in	h occurred at the to vestigation, in my o	me, date and pla opinion, death oc	ace, and due to the courred at the time,	cause(s) and manner date and place, and c	as stated. due to the cause(s)
	To the within 2.	3	29b. Signature and title of certifier	11	10	29c. Licens			29d. Date signed (Mo	
k	010		30. Name a d address of person who c	ompleted cause of de	ath (Item 23a) (Type,	Print)	1/2001	000 56	102/28	2005 4021204
	Stå Registr		31. Date liled (Month, Day, Year) AUG 0 2 2005	32. Registra	r's Signature	,0.0	JV (9V C)	201		7

			4	For State Registrar		St	tate of	Marylar		artmen <i>rtificat</i>				Mental Hy	giene Reg. N	005	251	63
	1	Physicia	10	1. Decedent's Nan	ne (First, Midd	le, Last)								2. Date of D Month	Day		3. Time	
		/Medic	al	I SABEL 4a. Facility Name	(If not inctitution	n cive stree	at and numb	nar)			OBIN Town, or		of Death	JULY	28 4c.	2005 County of Deat	5:00	_ A M
	1-1	Examin	er	SLADE I						,	TIMO					BALTI		
		Funeral	T)	5. Social Security	Number	6. Sex 1 ☐ M	7.	Age (In yrs.	last birthday,	If Under Months	1 Year Days	If Unde Hours	r 24 Hrs. Min.	8. Date of 8 (Month, D	inth ay, Year)	9. Birti Co	nplace (State untry)	or Foreign
ວ		Director		217-38- Usuat Residence		I C M	201	99_	Yrs.					10/24/	1905		MD	
20		yland	Ì	10a. State	10b. Count			10c. Ci	ty, Town or L								10d. Inside	•
SO 1		Ba-f el	ctor	MD		IMORE			BAL	TIMOR								s 2X No
23		death with the Maryland time 23a or 28a-f ehow ir must be traffled at	Funeral Director	7503 PA		CUTC	AVENIII			10f. Zip	208				Tog. Citi	zen of What Co U.S.		
رف		death me 23	erai	11. Marital Status	AKK HEI	12.1	Was Deced	ent Ever in U	J.S. 13.			lispanic C	origin? (Sp	ecify Yes or N Rican, etc.)	lo-	14. Race - Ame Bfack, White	ncan Indian,	
j	9	or Ita	/ Fur	1 Never Man		i i	Armed Ford 1 ☐ Yes 2 If Yes, Give			1 Yes, spe				rican, oic.,		Specify: Wh		
.}	5-0036	72 hours after death with the Marylan insturet, or Itame 23a or 28a-f show dical Examinat must be multified at	Completed by	3 Widowed		nt's Education	Year or Dat	es:	16a. Dece	edent's Usu	al Occup	ation			16b. Kii	nd of Business/	Industry	
1	215	c	piet	(Spe	ecify only high	est grade co	mpleted) Cotlege (1-4	for 5+)	(Give	DO NOT u	rk done	during me	ost of work	king				
3	12	be filed withing tal Hygiene. d other therevent, the Meneral	Соп				4		HOM	EMAKE	R	19 Mot	bods Nam	e (First, Middl	A Maiden	OWN HON	1E	
2	and		Be	17. Father's Name	e (First, Middle	, Last)			MTI	LER			NRIE		e, maioeri		JEFMAN	
. J	ary	s 1 and 2 should be i f Health and Mental i item 27 is marked o other traumatic eve	<u>۲</u>	19a. Informant's	Name/Relation	ship (Type,	Print)		19b. Mai	ing Address		and Num	ber or Ru	ral Route Num		r Town, State, 2	Zip Code)	
	Z	ss 1 and 2 of Health a litem 27 is rother tra		LARRY)N / S	ON	0.01				RIDG	E DR	IVE - 0	-	MILLS:		1117
J	ore	m Q			2 Cremation		oval from S	1010	Place of Disp cemetery, cri EB SHA	matory or o	other plac		07/2			STERSTON		
3486	Baltimore,	t. Partmer		4 ☐ Donation 21. Signature of	5 Other (Un								BROS.		
M	Ba	Depa Impo any is		Roc	~	15	Z	$\overline{}$								SVILLE,		208
H		4		23a. Part 1. Enter shock, or he	r the disease, eart failure. Li	or complicati st only one c	ause on ea	ch line.									Approxim Interval B Onset an	etween
	ja .	Physician /Medical		fmmediate Cause disease or condit resulting in death	tion	a	C74	RON	CC	rna	2101	224	_نال_	DAR PAI	Corr	APSE		
		Examiner					Due to (o	r as a conse	quence or):			. (2n)	D FAI	س	RE		
		P #	ner	Sequentially list of any, leading to cause. Enter Uncause (Disease)	conditions, immediate derlying	Į "−	Due to (c	r as a conse	quence of):				-					
		be executed sicien and burial-transit	Examiner	that initiated ever resulting in death	115	c	Due to (c	r as a conse	quence of):									
	8760,	ate be er hysicien the buria	icai E			L d												
	89	ortificat ing phy e as th	Medi	IF FEMALE:														
	Box 6	leath certifica attending ph I for use as th	lan/	23b. Was decede in the past	12 months?	23c.	1 Live bii	ome of pregr th 2 ☐ Fet int at time of	tal death 3	☐Ectopic p		У			į.	23d. Date of de Month	livery Day	Year
	P.O.	the de	Physician/Med	1 ☐ Yes 2 9 ☐ Unknov			9□ Unkno											
		To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	þ	Part II. Other sign	nificant condi	tions contrib	outing to de	ath but not re	sulting in the	underlying	cause gr	ven in Pa	rt I.		itobacco u Yes 2	use contribute to	the cause of the c	f death? Unknown
	Division of Vital Records,	ie law require has been sig ge 2 should b	Completed	BRTEU	(0 SC	CER	OTTO	_ CA	NOM	لاحزر	المار	Z	XSE	SE 24a. W	topsy	24b. Were a	utopsy finding completion o	s available cause of
	E	ysician: The is certificate hidirector, page	Com											1 Yes		death? 1 ☐ Yes	700	
	VIE	sician: Th certificate irector, pag	Be	25. Was case ref examiner? 1 \(\text{Yes} \) 2	ferred to medi	Hos	pital:	nationt 2	☐ ER/Outpati	ent 3 D	Ot Ott	hor		ith <i>Check onl</i> Iome 5 ☐ Re		6 Other (Spe	SUA	35
	J of	ding Phys n. After this funeral di	n: To	27. Manner of De	eath			f Injury n, Day Year)	28b. Time	of	28c. Inju Wo			28d. Describ		-	TA	nere
	sior	death. ctor: After y the funer	catic	1 Accident 2 Accident 3 Suicide	5 ☐ Pend inve: 6 ☐ Coul	stigation				М		Yes 2	□No	29t Location	(Street or	nd Number or R	um I Pouta M	umber
	Divi	after d Direct	Certification:	4 Homicid	data	rmined	28e. Place buildin	of Injury - At ig, etc. (Spec	home, farm, : city)	street, racto	иу, опісе			City or 7	own, State	9)	urar riodio in	arribor,
		To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	edicai C	29a. Certifier (Check only	1 Certif	ying Physici al Examiner	: On the ba	sis of examir	nowledge, de nation and/or	ath occurre	d at the t	ime, date opinion, d	and place death occu	a, and due to thurred at the time	ne cause(s e, date and) and manner a d place, and du	s stated. e to the caus	9(s)
		othe vithin 2 o the	Med	one) 29b. Signature a	nd title of certi	fier	and mann	er stated.)	HIN	9c. Lisen	se numbe	er c	G ₂	29d. Da	ite signed (Mon	th, Day, Year)
		4		1 (-	tou	للحو	- 12	- 6	<u> </u>		لمر) 2	اله	80		7/2	8/0	5
		0		30. Name and ac	dress of person	on who comp	bleted cause	of death (Ite	em 23a) (Typ	e, Print)	2	JE	ب رن	2 3	RAC	Tonh	5	(>10
	*	St	ate	31. Date fifed (M				istrar's Sig	nature	hoost	11	v ~			1>,,_	(-)	<i>y</i>	101
		Regist	rar		AUG	0 2 201	Ub 🦼	a series	15.	875								

		4	For State Registrar		State	e of Ma	arylan		artmen rtificat			ind M	ental Hy	giene Reg. No	005	251	6 li
3.72	Physicia		1. Decedent's Name (I	First, Middle,	Last)			1	ROSEN	BAUM			2. Date of De Month	ath Day 2	Year Zoo S	3. Time of I	Death V2 M
	/Medic		4a. Facility Name (If no	ot institution,	give street and	number)			4b. City,	Town, or	Location o	f Death	,,0.01		County of Dea		•
	Examin	er	SINAL H						BAL	TIMO	me C	277				N/A	
E.	Funeral		5. Social Security Num		5. Sex 1 X M 2 □			ast birthday)	If Under Months	1 Year Days	If Under 2	24 Hrs. Min.	8. Date of Bir (Month, Da	th y, Year)	9. Bi	rthplace (State or ountry)	
- ×	Director		216-38-4		1 KM 2 L		62	Yrs.					03/05/	1943		MD ME)
	and and		Usual Residence of De 10a. State	0b. County			10c. City	y, Town or Lo	ocation							10d. Inside Cit	y Limits
	Many -1 • hc	ţŏ	MD	BALT	IMORE		OW	INGS I	MILLS							1 🗆 Yes	2 X) No
	or 28e	lec	10e. Street and Numb	er					10f. Zip	Code				10g. Citiz	zen of What C	ountry?	
5	death with the Maryland ms 23s or 28e-f ehow rmust be rodiffed at	Funeral Director	12011 GARI	RISON						1117					.S.A.		
	r dea	ne	11. Marital Status	V	Ame	Decedent d Forces? es 2 🔀	Ever in U.	S. 13.	Was Decei	dent of Hi cify Cuba	spanic Orig n, Mexican	gin? (Spe i, Puerto f	cify Yes or No Rican, etc.))-	 Race - Am Black, Wh 		
36	s afte	by Fu	1 Never Married		If Yes	es 2 🔼 , Give or Dates:	No		1 ☐ Yes	2 💢 No	Specify:				Specify: W	HITE	
215-0036	72 hours after natural', or ite	ed b		5. Decedent's		OI Dates.		16a. Dece	dent's Usu	al Occupa	ation			16b. Kir	nd of Busines	s/Industry	
215	within 72 ene. then "na te Media	plet	(Specify Elementary/Second	, ,	grade comple	ted) ge (1-4or:	5+)	(Give	kind of wo DO NOT u	rk done a se retired,	<i>furing</i> most)	t of workir	ng				
212	d with giene er the	Completed	Ziomontary/3000ng	12	00.110	90 (1.101)		INVE	STOR						ESTAT	E	
pu	be filed tal Hygi d other event, I	Be	17. Father's Name (Fig.	rst, Middle, L	ast)		D.C	CENDA	18.4				(First, Middle	, Maiden		CENDL OOM	4
yla	ould be Mental Marked o	2	HYMAN				RU	SENBA		///	I D.		/ Clauda Africa h	a. Cit. a		SENBLOOM	1
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Montain Hygiene. 1 of Health and Montain Hygiene.		19a. informant's Nam						•	,					Town, State,	S, MD 21	117
	es 1 and 2 of Health of litem 27 i		GERALDINE 20a. Method of Dispos		DAUN /	WIFE	20h P	lace of Disp	nsition (Na	me of	1		ate eta		cation - City o		.11/
5	ages intof intof t: if it	H	1 Burial 2 □ 0	Cremation 3		rom State	ΑŅŞ	SHE EM	ŢŅXH'	other plac	e)	07/2	1 /2005	DAL	TIMODE	MD	
Baltimore,	permit. Pages Depertment of the important: if ite eny injury or of once.		21. Singler of Fuge		_//		AI	Z CHA	2. Name ar						I RDOS	., INC.	
B	Depermination of the contract		MAININ	ND	uga	-			8900	RETS	TERST				SVILLE		808
			23a. Part1. Enter the shock, or heart f	disease, or o	opplications t	hat cause on each I	d the deat									Approximate Interval Betv	veen
	Physician	8	Immediate Cause (Findisease or condition		-			warks	420	STAG	KE					Onset and D	
XXX.	/Medical Examiner		resulting in death)	9			a conseq										
+	Examine		Sequentially list cond	itions,	b	o to for as	a conseq	union offi									
	led 1sit	nlne	dany, leading to immicause. Enter Underly Cause (Disease or injustrat initiated events	ring	0.	erec que de	r ar elonnee q	and too ony.									
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Las	st	c. Du	e to (or as	a conseq	uence of):									
120	ate be ex hysician he burial	call			d												
89	tificate ng phys as the															_	
Вох	death certifice e attending pt d for use as t	an/h	IF FEMALE: 23b. Was decedent p				of pregna		⊒Ectopic p	regnancy				1 2	23d. Date of d	-	'ear
	e dea the at ned fo	Physician/Med	in the past 12 m 1 ☐ Yes 2 ☐ N 9 ☐ Unknown			Pregnant a Jnknown	it time of d	leath 5	Other (s	oecity)					WOTER	Duy .	ou.
P.0	res that the de signed by the a be detached f		Part II. Other significa	ant condition	s contributing	to death I	but not res	ulting in the I	underlying	cause dive	en in Part I		23e. Did	tobacco u	se contribute	to the cause of d	eath?
ds,	requires t sen signe rould be o	d by	COLONMY	MITERY	DISEAS								1 🗆	Yes 2(□No 3□F	robably 4	inknown
Ö	2 70	etec	1 (0.00	Corne t									24a. Wa	an	24b. Were a	autopsy findings a	available
Records,	has has	Completed	HYPERTEN	1010									auto perf	psy ormed?	prior to death?	completion of ca	use of
ta	icien: Th certificate rector, pag	e C	25. Was case referre	d to medical						-	26. Place	of Death	1 ☐ Yes	one)	1016	s 21 No	
of Vital	Physicien: r this certifica ral director, I	To B	examiner? 1 ☐ Yes 2 ☐ N	0	Hospital:	1 Inpati	ient 2 🗆	ER/Outpatie	nt 3 D	OA Oth					S □Other (Sp	ecify)	
	ding Ph h. After th funeral		27. Manner of Death	5 Pending	28a. l	Date of Inj (Month, Da	ury ay Year)	28b. Time o	of	28c. Injun Wor			28d. Describe				
Sio	Attending r death.	satle	2 Accident	investiga	ation				М	1 🗆	Yes 2 🗆						
Division	or Attendition death	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	20d 200.	Place of In building, e	ijury - At h itc. (Specia	ome, farm, s fy)	treet, lactor	ry, office			28f. Location City or To			Rural Route Num	ber.
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		20a Conflier 1	Cartituin	Physician: 1	to the new	I NE MILL BY	Milestra tim	th seemen	CAR IELS IN	na vietni ev	et places	end that the en-	PRINCIPLE.	an Emanner	as status	
	Fun etely	edical	(Check only 2 one)	☐ Medical E	xaminer: On	the basis manner s	of examina	ation and/or i	nvestigation	n, in my o	pinion, dea	ith occurr	ed at the time	date and	place, and di	e to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and til	tle of certifier					29	c. Licens	e number			29d. Dat	e signed (Moi	חth, Day, Year)	
	0/		> Jul	in	~ ~	424.	mp			RES	5- Ø5	1 jb		Tu	7 26,	2005	
1	D Y		30. Name and address	-	-	cause of						-					
(J		LUKE Y	WAN	1, 14)			HOSPIT			TIMOX	-6					, , ,)).
	Sta Regist		31. Date filed (Month	AUG n	2. 2005	32. Regist	trar's Signa	ature K.	Soneti						A.		

DHMH 17 Rev 1/2001

Putient Know As Kozenbaum, Sylvan

amend item#8, perFh, (846, 8/3/05 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** July 2005 Angeline Stephens 3:45 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 2306 Banning Place Prince George's Hyattsville 8. Date of Birth (Month, Day, Year)
Sept. 21, 19 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1926 Virginia 1 ☐ M 2 🖫 F 78 Director 228-28-0075 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f show the Medical Examinar must be notified at Director 1X Yes 2 ☐ No MD Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2306 Banning Place 20783 United States Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: 3 Widowed 4 □ Divorced African-American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 Is markad other than ' ury or other traumatic event, ILE Ma. Elementary/Secondary (0-12) College (1-4or 5+) 10 Hay Adams Hotel Customer Service 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Allen Warner Fannie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angelia Stephens-Tate 2306 Banning Place; Hyattsville, MD 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Metbod of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pag Department Important: I any injury o '4 ☐ Donation 5 ☐ Other (Specify) Washington National Aug. 2nd. 05 Suitland Maryland 21. Signatore of Furgeral Service Licenses 22. Name and Address of Facility LATNET 3 FUNERAL JP31 GEOR GIA AVE NW: WAShing Ton DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician Physician/Medical attending IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ned by the atter a detached for u 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 1 Tes 2 No Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 1 ☐ Yes 2 ☐ No 2 No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Desidence 6 Other (Specify) Hospital: 2 No P 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Mann f Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred After or Attending 1 V atural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital o within 24 hours af To the Funeral Di 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOBARAK 610 CARROLL AVE, STE 340, TAKOMA PARK, MD20918 KARINI 31. Date filed (Month, Day, Year) State AUG 0 2 2005 Registrar

DHMH 17 Rev 1/2001

		For	State of Maryland	d / Department of H	Health and Me	ntal Hygien	e
		State Registrar		Certificate of		Reg. N	
Physici		1. Decedent's Name (First, Middle, Last)			2	Date of Death Month D	ay Year 3. Time of Death 4:00 A M
/Medic		Mary Louise Sh		4b. City, Town, o	or Location of Death	July 34	o County of Death
Examir	er	Charleston		Cate	elliv 2n c	s ,	Baltimore
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Is	Months Davs	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Yea eb. 5, 19	9. Birthplace (State or Foreign Country)
Director		219-28-9111 Usual Residence of Decedent	77	Yrs.	F	eb. 5, 19	28 New Jersey
/land		10a. State 10b. County		, Town or Location			10d. Inside City Limits
ING 21215-0035 be filed within 72 hours after death with the Maryland ital Hyglene. Id other then "naturel", or items 23a or 28a-1 show event, its Medical Exprining roust be notified at	ctor	Maryland Baltimor	re Ca	itonsville			1 □ Yes 2 No
vith the	Director	10e. Street and Number	T DD 106	10f. Zip Code	200	10g. C	citizen of What Country?
eath v	eral	719 Maiden Choice	Lane BK 126 12. Was Decedent Ever in U.S	S 13 Was Decedent of h		v Yes or No-	USA 14. Race - American Indian,
_ p # # #	Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣 No		Hispanic Origin? (Specifian, Mexican, Puerto Ric	can, etc.)	Black, White, etc. Specify: White
Maryland 21215-0036 d 2 should be filed within 72 hours after th and Mental Hyglene. t7 is marked other then "naturel", or its treumatic event, the Mudical Examinin	Ď	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🕅 No			
72 h	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	oation during most of working d)	16b.	Kind of Business/Industry
within 72 ene.	duc	Elementary/Secondary (0-12)	College (1-4or 5+)	Homemaker	u)		n Home
be filed tal Hygid of other event, II	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name (F	First, Middle, Maide	on Sumame)
aryiar should be ind Menta in marked umatic ev	ToE	James Dean				1 Helm	
re, Maryla s 1 and 2 should f Health and Mer liem 27 is marke	4	19a. Informant's Name/Relationship (Ty) Edward Shea/Son	pe, Print)	19b. Mailing Address (Street 2403 Stonewa			
ther the		20a. Method of Disposition	20b. P	lace of Disposition (Name of emetery, crematory or other pla			Location - City or Town, State
POF		1 N Burial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify)		emetery, crematory or other pla iid RIdge Cemet		05 Pik	esville, MD
Baltimore, permit. Pages 1 ar Department of Hea Importent: If Item: any injury or other		21. Signature of Fungal Service License					al Hom21228c.
n 88 5 5 8		(CANA)	all				
		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the death ne cause on each line.	n. Do not enter the mode of dy	ng, such as cardiac or r	espiratory arrest,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ		urdiac a	Sport	e years
Examiner	Н	ſ.		derice orj.			
/ D ==	ner	Sequentially list conditions, any learned to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a consequ	uence of):			
60, be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	:				
- (1)	calE		Due to (or as a consequ	uence of):			
687 ifficate g physias the			Due to (or as a consequ	uence of):			
20 ≝ Es			Due to (or as a consequ	uence of):			
fox 6 th certifi tending processing to the second		23b. was decedent pregnant	Due to (or as a consequence). 23c. If yes, outcome of pregnation of the pregnation	incy	у		23d. Date of delivery
Geath certif		23b. Was decedent pregnant in the past 12 months?	d.	incy I death 3 ⊟Ectopic pregnanc	у		23d. Date of delivery Month Day Year
Geath certif	Physiclan/Medl	23b. Was decedent pregnant in the past 12 months?	d. 23c. If yes, outcome of pregnant Urive birth 2 Petal 4 Pregnant at time of de	incy I death 3 Ectopic pregnance eath 5 Other (specify)		23e. Did tobacco	
death certif	by Physiclan/Medl	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 The	d. 23c. If yes, outcome of pregnant Urive birth 2 Petal 4 Pregnant at time of de	incy I death 3 Ectopic pregnance eath 5 Other (specify)		23e. Did tobacco	Month Day Year ouse contribute to the cause of death?
SCOTOS, P.O. BOX to we requires that the death certification is been signed by the attending 2 should be detached for use a	by Physiclan/Medl	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 The	d. 23c. If yes, outcome of pregnant Urive birth 2 Petal 4 Pregnant at time of de	incy I death 3 Ectopic pregnance eath 5 Other (specify)		1 ☐ Yes : 24a. Was an	Month Day Year o use contribute to the cause of death? 2 No 3 Probably 4 American
SCOTOS, P.O. BOX to we requires that the death certification is been signed by the attending 2 should be detached for use a	by Physiclan/Medl	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 The	d. 23c. If yes, outcome of pregnant Urive birth 2 Petal 4 Pregnant at time of de	incy I death 3 Ectopic pregnance eath 5 Other (specify)		1 ☐ Yes	Month Day Year use contribute to the cause of death? 2 No 3 Probably 4 Monknown 24b. Were autopsy findings available prior to completion of cause of death?
I HECOrds, P.O. BOX to The law requires that the death certifate has been signed by the attending page 2 should be detached for use a	Physiclan/Medl	23b. Was decedent pregnant in the past 12 gonths? 1 Yes 2	d. 23c. If yes, outcome of pregna. 1	incy I death 3 Ectopic pregnance ath 5 Other (specify) ulting in the underlying cause gr	ven in Part I. 26. Place of Death (0	1 Yes 24a. Was an autopsy performed 2 1 Yes 2 N Check only one)	Month Day Year of use contribute to the cause of death? 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
HECONGS, P.O. BOX to The law requires that the death certifate has been signed by the attending page 2 should be detached for use a	To Be Completed by Physiclan/Medl	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Ave 9 Unknown 25. Was case referred to medical examiner? 1 Yes 2 No	d. 23c. If yes, outcome of pregnant of the birth 2 Fetal 4 Fregnant at time of degree of the birth of the second of the birth of the second of the birth of the	incy I death 3 Ectopic pregnance eath 5 Other (specify) ulting in the underlying cause gr	ven in Part I. 26. Place of Death (Coner. 4 In Nursing Home	1 Yes 24a. Was an autopsy performed 2 1 Yes 2 N Check only one)	Month Day Year of use contribute to the cause of death? 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 6 Other (Specify)
of VItal RECORDS, P.O. BOX t Physicien: The law requires that the death certif r this certificate has been signed by the attending rail director, page 2 should be delached for use a	To Be Completed by Physiclan/Medl	23b. Was decedent pregnant in the past 12 gonths? 1 Yes 2 Was case referred to medical examiner? 1 Yes 2 No Panding	d. 23c. If yes, outcome of pregnal 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown attributing to death but not resulted.	incy I death 3 □ Ectopic pregnance eath 5 □ Other (specify) □ ulting in the underlying cause gr EP/Outpatient 3□ DOA □ 28b. Time of liqury 28c. Injuny	ven in Part I. 26. Place of Death (Coner. 4 In Nursing Home	1 Yes 24a. Was an autopsy performed? 1 Yes 2 N Check only one)	Month Day Year of use contribute to the cause of death? 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 6 Other (Specify)
SION Of VITAL RECORDS, P.O. BOX tending Physicien: The law requires that the death certificate has been signed by the attending or: After this certificate has been signed by the attending the funeral director, page 2 should be detached for use a	To Be Completed by Physiclan/Medl	23b. Was decedent pregnant in the past 12 gonths? 1 Yes 2 Was case referred to medical examiner? 1 Yes 2 No	23c. If yes, outcome of pregnant of the birth 2 Fetal 4 Pregnant at time of de 9 Unknown of the birth of the	Incy I death 3 □Ectopic pregnance eath 5 □ Other (specify) □ ulting in the underlying cause gr EP/Outpatient 3□ DOA □ 28b. Time of Injury M Other (specify) □ 28c. Injury Wo M 1□ Dome, farm, street, factory, office	26. Place of Death (Coner: 4 Nursing Homery at Tk? Yes 2 No	1 Yes 24a. Was an autopsy performed? 1 Yes 2 N Check only one) 5 Sesidence d. Describe how inj	Month Day Year Duse contribute to the cause of death? Day Year Duse contribute to the cause of death? Day Year Duse contribute to the cause of death? Day Year Duse contribute to the cause of death? Duse contribute to the cause of death? Duse contribute to the cause of death? Duse contribute to the cause of death? Duse contribute to the cause of death? Duse contribute to the cause of death? Duse contribute to the cause of death? Duse contribute to the cause of death? Duse contribute to the cause of death? Duse contribute to the cause of death?
SION Of VITAL RECORDS, P.O. BOX tending Physicien: The law requires that the death certificate has been signed by the attending or: After this certificate has been signed by the attending the funeral director, page 2 should be detached for use a	Certification: To Be Completed by Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 3 Suicide 4 Homicide Homicide	23c. If yes, outcome of pregnant of the pregnant at time of deal of the pregnant at time of deal of the pregnant at time of deal of the pregnant at time of deal of the pregnant at time of deal of the pregnant of the pregna	Incy I death 3 □Ectopic pregnance eath 5 □ Other (specify) □ ulting in the underlying cause gr EP/Outpatient 3□ DOA 28b. Time of Injury M 1□ Dome, farm, street, factory, office	26. Place of Death (the string Home ry at rk? Yes 2 No	24a. Was an autopsy performed? 1 Yes 2 N Check only one) 5 Nesidence d. Describe how inj	Month Day Year of use contribute to the cause of death? 2 No 3 Probably 4 Athenown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 6 Other (Specify) ury occurred and Number or Rural Route Number, te)
SION Of VITAL HECORGS, P.O. BOX tending Physicien: The law requires that the death certificate has been signed by the attending or: After this certificate has been signed by the attending the funeral director, page 2 should be detached for use a	Certification: To Be Completed by Physician/Medi	23b. Was decedent pregnant in the past 12 gonths? 1 Yes 2 Was case reterred to medical examiner? 1 Yes 2 No Panding 27. Manner of Death 1 Shatural Shatural 2 Accident 3 Suicide Could not be determined 29a. Certifier 1 Certifying Physical Indicators 29a. Certifier 1 Certifier 29a. Cer	d. 23c. If yes, outcome of pregnand to the pregnant at time of despiration of the policy of the pregnant at time of despiration of the policy of the pregnant at time of despiration of the policy of the policy of the pregnant at time of despiration of the policy of the policy of the pregnant at time of the policy of the policy of the pregnant at time of the policy	incy I death 3 □Ectopic pregnance eath 5 □ Other (specify) □ ulting in the underlying cause gradient and properties are seen to be a s	26. Place of Death (Coner: 4 Nursing Homery at rk?) 281 The cone in Part I.	24a. Was an autopsy performed? 1 Yes 2 N Check only one) 5 Inesidence d. Describe how inj Location (Street a City or Town, Sta	Month Day Year of use contribute to the cause of death? 2 No 3 Probably 4 Athenown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 6 Other (Specify) ury occurred and Number or Rural Route Number, te)
SION Of VITAL RECORDS, P.O. BOX tending Physicien: The law requires that the death certificate has been signed by the attending or: After this certificate has been signed by the attending the funeral director, page 2 should be detached for use a	To Be Completed by Physiclan/Medl	23b. Was decedent pregnant in the past 12 gonths? 1 Yes 2 Ho 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide Physical Examined 29a. Certifier Check only 2 Medical Examiner Medical Examiner Physical Examiner Physi	d. 23c. If yes, outcome of pregnant Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown attributing to death but not result Hospital: Inpatient 2 1 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hobuilding, etc. (Specify sician: To the best of my knowner: On the basis of examinat	incy I death 3 □Ectopic pregnance eath 5 □ Other (specify) □ ulting in the underlying cause gradient and properties are seen to be a s	26. Place of Death (0 ner: 4 \sum Nursing Home ry at rk? Yes 2 \sum No 286 286 me, date and place, and opinion, death occurred	24a. Was an autopsy performed? 1 Yes 2 Note that the time, date at the time, date at autopsy performed?	Month Day Year Duse contribute to the cause of death? Day Year Duse contribute to the cause of death? Day Year Duse contribute to the cause of death? Duse contribute to the cause of death? Duse contribute to the cause of death? Duse contribute to the cause of death? Duse contribute to the cause of death? Duse contribute to the cause of death? Duse contribute to the cause of death? Duse contribute to the cause of death? Duse contribute to the cause of death? Duse contribute to the cause of death? Duse contribute to the cause of death?
of VItal RECORDS, P.O. BOX t Physicien: The law requires that the death certif r this certificate has been signed by the attending rail director, page 2 should be delached for use a	Certification: To Be Completed by Physician/Medi	23b. Was decedent pregnant in the past 12 gonths? 1 Yes 2 Was case referred to medical examiner? 1 Yes 2 No Panding 27. Manner of Death 1 Shatural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only one) 1 Certifying Physical examination 2 Medical Examination 3 Suicide 1 Certifying Physical 3 Suicide 2 Medical Examination 3 Suicide 3 Medical Examination 4 Suicide 3 Medical Examination 5 Medical Examination	d. 23c. If yes, outcome of pregnant Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown attributing to death but not result Hospital: Inpatient 2 1 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hobuilding, etc. (Specify sician: To the best of my knowner: On the basis of examinat	incy death 3	26. Place of Death (0 ner: 4 \sum Nursing Home ry at rk? Yes 2 \sum No 286 286 me, date and place, and opinion, death occurred	24a. Was an autopsy performed? 1 Yes 2 N Check only one) 5 Inesidence d. Describe how inj Location (Street a City or Town, State at the time, date at 29d. D	Month Day Year Duse contribute to the cause of death? Day Year Duse contribute to the cause of death? Day Year Duse contribute to the cause of death? Duse Contribute to the cause of death? Duse Prior to completion of cause of death? Duse Completion of cause of death? Duse
SION Of VITAL HECORGS, P.O. BOX tending Physicien: The law requires that the death certificate has been signed by the attending or: After this certificate has been signed by the attending the funeral director, page 2 should be detached for use a	Certification: To Be Completed by Physician/Medi	23b. Was decedent pregnant in the past 12 gonths? 1 Yes 2 Was case referred to medical examiner? 1 Yes 2 No Panding 27. Manner of Death 1 Shatural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only one) 1 Certifying Physical examination 2 Medical Examination 3 Suicide 1 Certifying Physical 3 Suicide 2 Medical Examination 3 Suicide 3 Medical Examination 4 Suicide 3 Medical Examination 5 Medical Examination	d. 23c. If yes, outcome of pregnant Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown antributing to death but not result 28a. Date of Injury (Month, Day Year) 28a. Place of Injury - At ho building, etc. (Specify sician: To the best of my knowner: On the basis of examinat and manner stated.	Depth and on the underlying cause graph and some state of the second of	26. Place of Death (0 ner: 4 \sum Nursing Home ry at rk? Yes 2 \sum No 286 286 me, date and place, and opinion, death occurred se number	24a. Was an autopsy performed? 1 Yes 2 N Check only one) 5 Inesidence d. Describe how inj Location (Street a City or Town, State at the time, date at 29d. D	Month Day Year Duse contribute to the cause of death? Day Year Duse contribute to the cause of death? Day Year Duse contribute to the cause of death? Duse Contribute to the cause of death? Duse Prior to completion of cause of death? Duse Completion of cause of death? Duse
SION Of VITAL HECORGS, P.O. BOX tending Physicien: The law requires that the death certificate has been signed by the attending or: After this certificate has been signed by the attending the funeral director, page 2 should be detached for use a	Medical Certification; To Be Completed by Physician/Medi	23b. Was decedent pregnant in the past 12 gonths? 1 Yes 2 Ho 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Chartural 5 Pending investigation 2 Accident 3 Suicide 4 Homicide 4 Homicide 20 Medical Examiner 20 Medical Examine	d. 23c. If yes, outcome of pregnant Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown antributing to death but not result 28a. Date of Injury (Month, Day Year) 28a. Place of Injury - At ho building, etc. (Specify sician: To the best of my knowner: On the basis of examinat and manner stated.	Depth and a control of the fina	26. Place of Death (0 ner: 4 \sum Nursing Home ry at rk? Yes 2 \sum No 286 286 me, date and place, and opinion, death occurred se number	24a. Was an autopsy performed? 1 Yes 2 N Check only one) 5 Inesidence d. Describe how inj Location (Street a City or Town, State at the time, date at 29d. D	Month Day Year of use contribute to the cause of death? 2 No 3 Probably 4 Anknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 6 Other (Specify) uny occurred and Number or Rural Route Number, (e) s) and manner as stated. nd place, and due to the cause(s)

			For State	State of Ma	aryland / [rtment of			ental Hy	giene	กกร	25168
	•	11.134	Registrar 1. Decedent's Name (First, Middle, Last)			imouto or	Dodi		2. Date of De		.000	3. Time of Death
n	Physici			Stolbe	rg					Month July	28.	y Year 2005	2:50 P ^M
	/Medic Examin		4a. Facility Name (If not institution, give		-0		4b. City, Town,	or Location	of Death	oury		. County of De	
		•	Continuum Care	of Syk	esvill	e	Syk	esvi	11e			Carr	011
H	. Funeral		5. Social Security Number 6. Se		e (In yrs. last bir	rthday)	If Under 1 Year Months Days		er 24 Hrs. Min.	8. Date of Bird (Month, Da	h y, Year)	9. B	irthplace (State or Foreign Country)
	Director		219-10-0970	Å.	93	Yrs.				SEP 29	, 19	11	Maryland
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	m or Loc	ation						10d. Inside City Limits
	Many -f sh	ţ	Maryland Baltin	nore			р	ikesv	ille				1 ☐ Yes 2 No
	r 28a	Director	10e. Street and Number	IOLC		·	10f. Zip Code				10g. Cit	izen of What (Country?
	th wit		210 Hawthorne A	venue			2120	8(USA	
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. V	Vas Decedent of Yes, specify Cu	Hispanic C can, Mexic	origin? (Spe an, Puerto I	cify Yes or No Rican, etc.)	-	14. Race - Am Black, Wh	
36	in 72 hours after death with the Maryland i "natural", or items 23a or 28a-f show tedical Examiner must be notified at	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ I If Yes, Give Year or Dates:]	NO 1.6	1	☐ Yes 2☐No	Specif	y:			Specify:	White
9	tural		15. Decedent's Edu				ent's Usual Occu			_	16b. K	ind of Busines	s/Industry
715	nin 72 n "nat	Completed	(Specify only highest grad		(4)	(Give I life. E	kind of work done OO NOT use retir	during mo d)	ost of workir	ng			ř
212	filed within Hygiene. other than "	mo;	Clotheritary/decondary (0-12)	4		Sch	ool Adm					Educati	on
nd	I be filed ntal Hygie ed other	Be	17. Father's Name (First, Middle, Last)					18. Mot		(First, Middle,			
yla	2 should be to and Mental I is marked of aumatic ever	ပ္	Edward Boris S							ie Sto		<u> </u>	
Maryland 21215-0036	12 sh h and 7 is rr traurr		19a. Informant's Name/Relationship (T) Sophie Hollander S				g Address <i>(Stree</i> Hawthorn						1208
	ges 1 and 2 should t of Health and Mer If item 27 is marke or other traumatic		20a. Method of Disposition	rorner8/ w	20b. Place of	f Dispos	sition (Name of	1		ate TKGSVI.		ocation - City o	
nor	ages ant of tt: If it		1 ☐ Burial 2 💆 Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)				matory or other pla matory,		7/29	/05	В	altimo:	re. MD
Baltimore,	permit. Pages Department of H Important: If ite any injury or of		21. Signature of Funeral Service Licens			22.	Name and Addi	ess of Fac	ility				,
ä	Depa Impo any ir		Edward A. Gre	gorchik		1	Cremation 299 Free	on So Teric	ciety k Road	ot MD, d Balti	Ind Hore	e. MD 2	1228
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused ne cause on each lir	the death. Do	not ente	or the mode of dy	ing, such a	s cardiac o	r respiratory a	rrest,	,	Approximate Interval Between
	Physician	0	Immediate Cause (Final disease or condition	Pa	eumor	1 h G							Onset and Death
	/Medical Examiner		resulting in death)		a consequence								Jung 5
В	LAdimine	L	Sequentially list conditions,	Duals for as	a consequence	of):							Years
	ted.	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	01).							
16	al-tra	Examin	that initiated events resulting in death) Last	Due to (or as	a consequence	of):							
8760,	death certificate be executed. e attending physician and of for use as the burial-transit	dlcall		d									
9	rtifical ng phy as th	Medi	IE CENALE.								-1-		
Вох	death certific attending pl	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1 ☐ Live birth	of pregnancy 2 Petal death	3 🗆	Ectopic pregnan	су			:	23d. Date of de Month	elivery Day Year
о. В		Physician/Me	1 Yes 2 No	4☐Pregnant at 9☐Unknown	time of death	5 🗌	Other (specify)					Month	Day . Sai
٩.	by tac	Ph	Part II. Other significant conditions co	ntributing to death b	ut not resulting in	n the un	derlying cause g	ven in Pan	t i.	23e. Did to	obacco u	se contribute	to the cause of death?
ds,	es pe	d by			3		, ,			10	res 21	Ş 479 3 ⊡ F	Probably 4 Unknown
Records	> 40	lete								24a. Was	an	24b. Were a	autopsy findings available
Re	The law ate has b page 2 sl	Completed								autop perfo	rmed? 2 2 No	death?	completion of cause of
Vital	sician: Th certificate irector, pag	Φ	25. Was case referred to medical					26. Pla	ce of Death	(Check only o			22,10
Į V	S S =	To B	examiner? 1 ☐ Yes 2 🔀 🖺 o	lospital: 1 ☐ Inpatie	nt 2 ER/Ou	utpatient	3□ DOA O	her. 4	Nursing Hon	ne 5 🗆 Resid	dence (6 □Other (Sp	ecify)
n of			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Day	ry Year) 28b.	Time of Injury	28c. Inju			8d. Describe I	now injur	y occurred	
sio	Attending r death. sctor: After	catl	2 Accident investigation 3 Suicide 6 Could not be	On Division of last	unu AAbana fa			Yes 2		29f Location (9	Stroot an	ud Number or F	Rural Route Number,
Division	or A fter Direction by	Certification:	4 Homicide determined	28e. Place of Injubulding, etc	c. (Specify)	im, sire	et, ractory, office		-	City or Tov			idra riodio rumber,
-	Hospital	65	29a. Certifier 12 Certifying Phy	sician: To the best	of my knowledge	e, death	occurred at the	ime, date a	and place, a	and due to the	cause(s)	and manner a	as stated.
	To the Hospital within 24 hours a To the Funeral Completely filled	edic	(Check only 2 Medicel Exami	ner: On the basis of and manner sta	examination an ited.	nd/or inv	estigation, in my	opinion, de	eath occurre	ed at the time,	date and	i place, and du	ie to the cause(s)
	To th withir To th comp	M	29b. Signature and title of certifier	1. 1			29c. Licer	se number	r		29d. Dat	te signed (Mor	nth, Day, Year)
	^		I Will	The in	0		PS	258	(37	7		7/28/2	75
	3		30. Name and address of person who co	hpleted cause of d	eath (Item 23a)	(Type, F			,	,		44.0	7115
			31. Date filed (Month, Day, Year)	32. B egistra	ar's Signature	Hee	>+ 3°	7	(UPS)	tminst		MD	2115/
7	Sta Registr		AUG 0 2 20	ns 52.200	ar's Signature	do	uli						
Div	34-F	201	HOU 0 6 20	The state of the	ner d'	1							

05-05013 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend; unpend item/1,2,23a,PII,2/,28a-I,perME,G846,8;29;05 TI

State of Maryland / Department of Health and Mental Hygiene

_		•	Amend; unper	State of Ma		ertificate of			jiene eg. No. 200	5 25169
菜	Physici	20	1. Decedent's Name (First, Middle, Las					2. Date of Dea Month	Day Yea	
	/Medic	al	Mark W. Schar			4h City Town o	r Location of Deat	JULY h	25, 2005	
	Examin	er	48 B Mt.Royal Ave	Street and number,		ABERDEE	_		HARFORD	
δ	, Funeral		5. Social Security Number 6. S	ex 7. Ag	e (In yrs. last birthda) 42 Yrs.		If Under 24 Hrs Hours Min.	_ (Month, Day	, Year) 9. I	Birthplace (State or Foreign Country)
3	Director		213-68-3128 Usual Residence of Decedent	5	4Z 11s.			June 1/	, 1963 M	aryland
	ryland		10a. State 10b. County		10c. City, Town or					10d. Inside City Limits 1 ☐ Yes 2 No
	ith the Marylar or 28a-f ehow	Director	Maryland Harford	<u> </u>	Abei	deen		1	l 0g. Citizen of What	
	3a or 3		48 B Mt.Royal Ave	enue			.001		USA	
	me 2	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	. Was Decedent of H	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - A Black, W	mencan Indian, hite, etc.
36	within 72 hours after death with the Maryland ene. then "neturel", or iteme 23a or 28a-f ehow the Medical Exerciser most be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏋 Divorced	1 □Yes 2 XI If Yes, Give Year or Dates:		1 ☐ Yes 2XNo			Specify:	White
9-0	2 hou	ted t	15. Decedent's Ed	ducation	16a. Dec	edent's Usual Occup	pation during most of wa	rkina	16b. Kind of Busine	ss/Industry
218	Aithin 7	Completed	(Specify only highest gra	College (1-4or 5	+)	re kind of work done DO NOT use retire Laborer	d)	9	Constru	ation
d 2	filed v Hygie other t		17. Father's Name (First, Middle, Last)		1	alotel	18. Mother's Na	me (First, Middle,		CLOH
ılan	should be filed nd Mental Hygi marked other umatic event, I	To Be	Louis C. Schant	z			Ве	tty Hark	ness	
Maryland 21215-0036	2 sho and I is ma rauma		19a. Informant's Name/Relationship (r, City or Town, State	
	1 and Health Iam 27		Linda Greathouse,	Sister	20b. Place of Dis	Erie Stre position (Name of ematory or other place	et Havre	De Grace	e, Marylai 20c. Location - City	or Town, State
E O	Peges nent of nt: If It		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)			ematory I	07/	28/05	Baltimore	e, Maryland
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Department of Health and Mental Hyglene Important: if Item 27 is marked other then "natural", or Iteme 23a or 28a-1 ehow any injury or other traumatic event, the Medical Examination and Once.		21. Signature of Fineral Service Licer Thomas Gregor	Wy		22. Name and Addre Cremation 299 Frede	Society	Of Mary	land, Inc. ore, Mary	Land 21228
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do not e	nter the mode of dyir	ng, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death
ĵ.	Physician		Immediate Cause (Final disease or condition resulting in death)		Toxicity					Grissi and Beatt.
	/Medical Examiner			Due to (or as	a consequence of):					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence of):				11	
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):					
8760,	ate be executed hysician and the burial-transit	dical E		d.						
9	tificate ng phys as the	Aedic	IE SCHALE	·						
Вох	eath certific attending p for use as	lan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death	Ectopic pregnanc	у		23d. Date of Month	delivery Day Year
P.O. I	the de y the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time or death :	Other (specify)				
ds, P	Attending Physician: The law requires that the death certific rideath. sctor: After this certificate has been signed by the attending p by the funeral director, page 2 should be deteched for use as by the funeral director.	Completed by Ph	Part II. Other significant conditions of Methadone Use	contributing to death b	ut not resulting in the	underlying cause gr	ven in Part I.			e to the cause of death? Probably 4 Unknown
Division of Vital Records,	s been s been s shou	olete						24a. Was a		autopsy findings available to completion of cause of
Re	The lav	Som						perfor	med? death	1?
Vita	ician: Th certificate rector, peg	Be	25. Was case referred to medical examiner?	Hospital:		Ot		ath (Check only or		COME
of	Phys er this eral dir	7: To	1 X Yes 2 No 27. Manner of Death	28a Date of Inju		of 28c. Inju	4 🗆 140131119	1	ence 6 NOther (S ow injury occurred	
ion	utending death. ctor: Afte y the fun	atlo	1 Natural 5 Pending 2 Accident investigatio	7_25_05	4:18		Yes 2 No			
ivis	P te	Certification:	3 Suicide 6X Could not be determined	building, et	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (S City or Tow	n State)	Rural Route Number, 8 mt Royal Ave
	To the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate has Pompielely filled in by the funeral director, page 2		29a. Certifier 1 ☐ Certifying PI (Check only 2 ☐ Medical Example)	nysician: To the best minar: On the basis of and manner st	of my knowledge, de f examination and/or	ath occurred at the tri investigation, in my	me, date and plac opinion, death occ	e, and be to the curred at the time, of	MD manne	as stated
	To the within 2. To the tomplet	Medical	one) A 29b. Signature and title of certifier	and manner st	a190.	29c. Licen			29d. Date signed (M	
			Invate Fresh	all ma		0.C	.M.E.		JULY 25, 2	005
	200g		30. Name and address of person who	completed cause of o	death (Item 23a) (Typ		M. Camparam	DATTIMOT	DE MADSZI AN	TD 21201
	41/		31. Date filed (Month, Day, Year)	MULLI MI) 32. Registr	rar's Signature		N SIKEET	, DALIIMOR	RE MARYLAN	ID ZIZUI
	Sta Registi		AUG 0 2 2		and the the	parte				

29

DEBORAH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** July 2005 7:25 P M John David Sekercan 25 /Medical 4e. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 11641 Manor Rd. GLEN ARM
If Under 1 Year If Under 24 Hrs. \mathtt{BALTO} . 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 DM 2 □ F Director 46 217-64-0155 Dec. 26 1958 MA Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then *neture!', or Items 23a or 28s-f show eny injury or other traumatic event, the Medical Examinar must be routined at onge. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director MD Baltimore Glen Arm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11641 Manor Rd. 21057 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ₹ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Senior Software Engineer Computer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kirkor Sekercan Jeannette Chirinian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa J. Thurin/sister 11641 Manor Rd., Glen Arm, MD 21057 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 7/29/05 1 █ Burial 2 □ Cremation 3 □ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD Signature of Funeral 22. Name and Address of Facility Lemmon emmon Funeral Home of Dulaney Valley, Inc. Lowell M. 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Do not enter the mode of dying such as cardiac or respiratory arrest, Approximate Interval Between Conset and Death Immediate Cause (Final disease or condition **Physician** /Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 2 □ No 9 Unknown 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? res 22 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. 28d. Describe how injury occurred After t Injury at Work? 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral (Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Cancer Institute Rodrigo Erlich, 2401 W. Bevedere Ave., Balto., MD 21215 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 0 2 2005

DHMH 17 Rev 1/2001

ORIGINAL

		•	1 - For Amend Item 17	State of Manyland, per The 6840 8	/ <u>Departn</u> Certific	nent of H	ealth and I Death	Mental Hygi	ene	05 25172
	Physici	an	1. Decedent's Name (First, Middle, Last)	T Sala				2. Date of Death Month		Year 5'20 4M
Ē	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)	4b.	City, Town, or	Location of Death	D	4c. County	of Death To rd
	uneral		5. Social Security Number 6. Sex 219-05-9515	7. Age (In yrs. last		Inder 1 Year oths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, January 1	Year) 4,1919	9. Birthplace (State or Foreign Country) Maryland
Manyland	a-f show	tor	10a. State 10b. County MD Harford		Fown or Location	1				10d. Inside City Limits 1 ☐ Yes ②☐ No
h with the	3a or 28 st be not	Funeral Director	10e. Street and Number 1207 Mountain Ros	ıd	10	f. Zip Code	85			What Country? tates of America
5-0036 72 hours after death with the Maryland	of other than "natural, or itams 23s or 28s-f show event, the Medical Examiner must be notified at	by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1		Decedent of Hi , specify Cuba les 2 \$\overline{\Omega}\$ No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Blad	se - American Indian, ck, White, etc. y: White
1215-00 within 72 hou	than "nature or Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		16a. Decedent's (Give kind life. DO N	of work done of OT use retired	lurina most of wor	rking		usiness/Industry
be filed	marked other than 'matic event, the wa	To Be Co	17. Father's Name (First, Middle, Last) Charles Borghese		nome	naker	18. Mother's Nan	ne (First, Middle, M	OWN H	
e, Maryla	trau		19a. Informant's Name/Relationship (Ty.) George L. Sohn J	r. (Son)	1207 Mo	untain	and Number or Ru	oppa, Mar	yland_	21085
Baltimore,	ortant: If its njury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service License	emoval from State Nation	etery, cremator al Crem	or other place atory	08/	02/05 F	alls C	City or Town, State hurch, Va.22042
B F	tapo any once	-	23a. Part1. Enter the disease, or compli	cations that caused the death. I	8/28	Liberi	ry Road,	Randalls	rown, M	ral Directors,In D. 21133-4724 Approximate Interval Between
//\	/sician ledical aminer		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)		Nd 5	TARE	Copp			Onset and Death
	ę	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	noe of):					
8760, 7	ohysician and the buriat-transit	Ical Exa	that initiated events resulting in death) Last	Due to (or as a consequen	nce of):					
ecords, P.O. Box 68760, ~ (attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, out <i>co</i> me of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	eath 3 Ecto	pic pregnancy er (specify)				te of delivery onth Day Year
ords, P	been signed by the should be detached	þ	Part II. Other significant conditions cor	tributing to death but not resulting	ng in the underly	ring cause give	en in Part I.		acco use cont	nibute to the cause of death?
T g	ate has page 2	Completed						24a. Was an autopsy perform 1 ☐ Yes 20	ed?	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
of Vita g Physician:	er this certificate ieral director, paç	n: To Be	27. Manner of Death	ospital: 1 Inpatient 2 ER 28a. Date of Injury (Month, Day Year)	Bb. Time of	DOA Othe	ar: 4 🗌 Nursing H	ath (Check only one lome 5 Resider 28d. Describe how	ice 6 0th	
Division of Vital	iret deatit. Virector: Aft n by the fun	Certification;	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	Injury N e, farm, street, f	10	Yes 2 □ No	28f. Location (Stre City or Town,		per or Rural Route Number,
B Hospitel	within 44 frouts after beauti. To the Funerel Director: After this certific completely filled in by the funeral director,	edical Ce	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examin	sician: To the best of my knowle her: On the basis of examination and manner stated.	edge, death occ n and/or investig	urred at the tim ation, in my op	ne, date and place pinion, death occu	a, and due to the car arred at the time, da	use(s) and ma	anner as stated. and due to the cause(s)
Toth	To th	Me	29b. Signature and title of certifier	l'a Nogit.		29c. License		_		d (Month, Day, Year) 9/2005
	18		30. Name and address of person who con ALY NAGUIT. 31. Date filed (Month, Day, Year)	mpleted cause of death (Item 23)	3a) (Type, Print	TE L	5938) 1r. #20)3 Fo	Rest	9/2005 Hill Mb 21050
DHMH	Sta Registr 17 Rev 1/2	rar	AUG 0 2 2005	32. Registrar's Signature	Sperke	ş				

Howard Slusher 05-05 MUN

5132	usne	L	riease	State of Ma					•	•	Die,		
7132			For State	State of Ma	iryland /		tificate of L	ealth and M		ierie _{eg. N} 2 () (וב י	05173	į.
**	3.50		Registrar 1. Decedent's Name (First, Middle, Last)		061	uncate of t	Jean	2. Date of Deat		13	3. Time of Death	
F	hysici		Howard T. Slush	er					July	30°	2005	1408	М
)	/Medic Examin	- 21	4a. Facility Name (If not institution, give			T	4b. City, Town, or	Location of Death		4c. County	of Death		_
		S	204 Cranbrook Roa	ad			Timoni	um		Balt	imore		
	uneral		5. Social Security Number 6. Se	x 7. Age ŽM 2□F	(In yrs. last b	virthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)		ace (State or Foreigny)	gn
	rector		219-30-2633		71	115.			May 4, 1	L934	WV		
yiand	MOI II		10a. State 10b. County		10c. City, To	wn or Lo	cation				10	d. Inside City Limit	S
Mar	in particular in the particula	ctor	MD Baltimo	re	Co	ckey	sville,					1 ☐ Yes 2 🔀 N	0
ij th	or 28	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of	What Count	ry?	
ath w	23a		204 Cranbrook Ro					030		USA			
er de	Darr	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?		13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Spe In, Mexican, Puerto	cify Yes or No- Rican, etc.)		ce - America ck, White, e		
)36 Irs at	ye.	by F	1 ☐ Never Married 2 ☑ Married 2 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 N If Yes, Give Year or Dates:	.0	1	☐ Yes 2X No	Specify:		Specif	y: Whi	te	
Maryland 21215-0036 at 2 should be filed within 72 hours after death with the Maryland the and Manial Hygiene.	ical E	Completed	15. Decedent's Edi (Specify only highest grad	ucation	16	a. Deced	ent's Usual Occupa	ation	20	16b. Kind of B	usiness/Ind	ustry	_
E ig .	L Mari	npie	Elementary/Secondary (0-12)	College (1-4or 5	+)			during most of worki	ng				
Ped y	Here		12	N/A_		F	ood Clerl		(F:		tail :	Food	_
De fi	o ver	Be	17. Father's Name (First, Middle, Last)	L				18. Mother's Name		Maiden Sumar	ne)		
Noulc d Me	mark	၉	Montaque T. Slus		10	h Mailin	a Address (Street	Rosa Sha and Number or Rura		City or Town	State Zin	Codel	_
Man Range	27 is		Delores Slusher/		4			k Road Co				,	
s a ar	othe	-	20a. Method of Disposition		20b. Place	of Dispo	sition (Name of			20c. Location			
Page Page	int: H	1	1 ☐ Burial 2 🛣 Cremation 3 ☐ I	Removal from State)	Natio	nal	natory or other place Crematory	2005	۷,	Falls	Churc	ch, VA	
Baltimore, permit. Pages 1 ar Department of Hea	Important: if item 27 is marked other then "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Mudical Executor must be notified at once.		21. Signature of Funeral Service Licery	100		T.e	. Name and Addres	ss of Facility eral Home	of Dula	nov Va	110**	Tmo	
0 88	투출점			Michael J.		e 10	w. Pador	nia Road	limonium	MD 2	1093	THE.	
797- 200-			23a. Part . Enter the disease, or comp shock, or heart failure. List only of	one cause on each lir	16.				or respiratory arri	est,	Į.	Approximate Interval Between Onset and Death	
	sician edical		Immediate Cause (Final disease or condition resulting in death)				r wound	to Head				011001 4110 004(1)	
-	miner			Due to (or as	a consequenc	e of):							
	198	e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or as	a consequenc	e of):							_
≥ B	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C									
760, (7) te be executed	lysician and ne burial-transit		resulting in death) Last	Due to (or as	a consequenc	e of):							
	hysic the bu	dicai	(d									
. Box 68	attending phy I for use as the	Physician/Medi	IF FEMALE:	23c. If yes, outcome	of pregnancy								
Box eath cert	for u	cian	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal dea		Ectopic pregnancy Other (specify)				ate of deliver onth	y Day Year	
P.O.	y the	hysi	1 Yes 2 No 9 Unknown	9□ Unknown									
Records, P.O The law requires that the	ete has been signed by the a page 2 should be detached	by P	Part II. Other significant conditions co	ontributing to death b	ut not resulting	j in the u	nderlying cause give	en in Part I.	23e. Did tol	bacco use con	tribute to the	cause of death?	
ord:	en sig	ed							1 🗆 Ye	es 2 No	3 🗌 Proba	bly 4 ∐Unknov	٧N
e C C	as be	Completed							24a. Was a autops		Were autop	sy findings availab	le
<u>ت</u> ۽	page,	Con							1 Yes	med? 2 □ No	death?		
of Vital Physician:	certificete rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			· all pool Oth	26. Place of Deatl					
Division of Vital Records, for Attending Physician: The law requires tale death.	r this	To To	1 X Yes 2 No 27. Manner of Death	1 ∐ Inpatie	nt 2 ER/(Outpatier Time of	3 DOA	4 INDISHING ITO	me 5 Reside			SCENE	
Vision Attending	: Afte e fune	Certification:	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	1 30 U	1	Injury	AAOU	k? Yes 2 No		T SIFCT	1016		
ViS Atte	ector by th	tifica	3 Surcide 6 ☐ Could not be determined	110-14	ury - At home,		eet, factory, office		28f. Location (S)	treet and Num	ber or Rural	Route Number,	-
Div Ital or A	ed in	Cer		Daliding, at		1 ve	ticle		Timon	n, State) ZGU	CVIAISV	ice revard	
Hospital of	To the Funerel Director: After this certific completely filled in by the funeral director,	edicai	(Check only 2 Medical Exam	ysician: To the best niner: On the basis of	examination i	lge, death and/or in	occurred at the tin vestigation, in my o	ne, date and place, pinion, death occurr	and due to the c	ause(s) and m	anner as sta and due to	ited. the cause(s)	
To the I	o the	Med	one) 29b. Signature and title of certifier	and manner sta	ated.		29c. Licens	e number	2	9d. Date sign	ed (Month, E	Dev. Year)	
F 3	F 8			11 17									
	10		30. Name and address of person who o	completed cause of c	leath (Item 23a	a) (Type		CME		July,	31, 2	.003	
	(JACU M.	The mid	111 P		· ·	imore, Ma	aryland	21201			
	Sta		31. Date filed (Month, Day, Year) AUG 0 2 2005	32. Registr	ar's Signature	1							
· Cont	Regist	ar	7,000 0 % 2003	De selvino	St. A	TOSA!							-

Registrar DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	aryland		artmen rtificate			and Me		giene 109. N2 0 ()5	251 7 4	
	Physic		1. Decedent's Name (First, Middle, La. DANTEL	SZYMA	Nsk	I					Date of Dea Month	Day	Year 2005	3. Time of Death	
). 	/Medi Examir		4a. Facility Name (If not institution, give	street and number)			4b. City,		Location o	f Death		4c. County			
	Funeral Director		215 30 7749	ex 7. Ag ▼ M 2 F	70	ast birthday) Yrs.	If Under Months	1 Year Days	If Under a	Min.	B. Date of Birth (Month, Day 100. 28		9. Birth	place (State or Foreign ntry) yland	1
	Maryland -f show fied at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne At	runde1		Town or Lo								10d. Inside City Limits 1 ☐ Yes 2X No	
	th with the 23s or 28s	Funeral Directo	10e. Street and Number 5237 - 4th Str				10f. Zip	Code 212	.25			U.S.		ntry?	
980	72 hours after death with the Maryland natural', or Itams 23s or 28a-f show dical Examinet roust be notified at	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 2 1 If Yes, Give Year or Dates:	Ever in U.S No		Was Deced f Yes, spec			gin? (Spec , Puerto Ri	ify Yes or No- can, etc.)	1	e - Americk, White,		
21215-0036		Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 8th		5+)		dent's Usua kind of wor DO NOT us ninist	k done d e retired)	tion uring most	of working	7	Kop-Fle	≥x	ompany	
Maryland	should be filed withir Ind Mental Hygiene. s markad othar than umatic event, Ire M	To Be (17. Father's Name (First, Middle, Last) Alexa	nder Szym	anski					Jenn	ie Woz	Maiden Suman Wiewicz			
	s 1 and 2 should f Health and Men item 27 Is marks othar traumatic		19a. Informant's Name/Relationship (Beverly Szymansk	** *		5237	- 4th	Str				r, City or Town, e, Mary			
Baltimore,	9 ○ - - =		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		CO	ace of Dispo metery, crem view	natory or of	her place	· 1	Dai 3/1/20		20c. Location - Baltimo		own, State Maryland	
Balt	permit. Pag Depurtment Impurtant: I any njury o		21. Signature of Funeral Service Licen	namuse	ushi	4		itch	ie Hi	ghway	7 Balt			e, P.A. land 21225	
I,	Pirysician		23a. Part 1. Enter the disease, or corn shock, or heart failure. List only Immediate Cause (Final disease or condition	olications that caused one cause on each line a. ACUTE	ne.				n, such as o		_	est, SHOCK		Approximate Interval Between Onset and Death	
8760,	/Medical Examiner bhysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to inimediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. ACUTE Due to (or as c. ANOX Due to (or as d.	a conseque	ence of): 2-ESPI ence oi): ENUE	RAT	oei	1	FAI				14 hors	
.O. Box 6	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pre					23d. Dai Mo	e of delive	∂ry Day Year	
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions o	ontributing to death b		ting in the ur			n in Part I.	e				ne cause of death?	
Vital Record	The law ate has b page 2 s	Completed	- CAD - COPD	Hypert	ens	هـــــــــــــــــــــــــــــــــــــ					24a. Was a autops perform	ned?	rior to cor feath?	psy findings available impletion of cause of	_
of Vita	Phyaician: T this certificate ral director, pa	To Be (25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	Hospital: 1 Inpatie	int 2 🗆 E	P/Outpatien	t 3 DO	Otho			Check only on		ar (Specify	()	
Division o	ing After une	Certification;	27. Manner of Death 1	28a. Date of Inju (Month, Day	y Year)	28b. Time of Injury	M 28	lc. Injury Work' 1 Y	at ? es 2 □ N		d. Describe ho	w injury occurr	ed		
Divi	p ∰ ig ∈		3 Suicide 6 Could not be determined	building, etc	c. (Specify)						City or Town	ı, State)		l Route Number,	
	To the Hospital within 24 hours a To the Funeral I completely filled	ledical	one) 2 Medical Exam	ysician: To the best of iner: On the basis of and manner sta	examination	rledge, death on and/or inv	estigation,	in my opi	nion, death	l place, and n occurred	d due to the ca at the time, da	ause(s) and ma ate and place, a	nner as st and due to	ated. the cause(s)	
	To with	Z	29b. Signature and title of certifier WIRUT CES	ZEWOLD	(m.	(a.	İ	License	10007	ı		9d. Date signed プレレン	22	2405	
6	, `\		30. Name and address of person who define the state of th	completed cause of d	eath (Item :	23a) (Type, I	Print)	%b	no u	P (CAVRA	+ Ra	Hann	OM MAD 212	73
ç	Sta Registi		31. Date filed (Month, Day, Year) AUG 0 2 2	32. 1 Sgistra	ar's Signatu	& A	mel		•		21.66	- 130		ore moziz	-3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registraemend item 35 PER FH G846 8/ Septificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death **Physician** /Medical 4b. City, or Location of Deat 4c. County of Death **Examiner** (In yrs. last birthday) If Under 24 Hrs. Date of Birth Month, Day, Year, 7-13-1938 Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2/□XF Hours -34-8888 Yrs. Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r then "neturel", or items 23e or 28e-f show the Wedlest Examiner must be notified at 10d. Inside City Limits MD Baltimore Riverview **Funeral Director** 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 919 Catawba Ct 21227 U.S.A. death 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🔼 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: lf Yes, Give Year or Dates: Specify: White Be Completed by 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) House Keeper Cleaning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be I nent of Health and Mental I ant: If item 27 ie marked o John Albert Brown Ceceila Lillian Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 in Sharon Hutchins/Daughter 15 Hampton Rd. Linthicum MD 21090 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 08-04-05 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Si mature of Funeral Service Lic Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdwone 21227 23a. Part1. Enter the disease or complications that caused the shock, or heart failure. List only one cause on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner PSTRUCTIVE LUMGDISEASE UNKNOWN the burial-transit that initiated events resulting in death) Last Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent oregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 3 signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 12 Yes 2 No 3 Probably 4 Unknown MUMMY EMBOLISM 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? 1 ☐ Yes 2□ No 212 No To the Hospitel or Attending Physicien: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ Ho Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: Division 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier mantha 29b. Signature and title franchicula 29c. License number 29d. Date signed (Month, Day, Year) TUCY 31, 2005 11 BAYTMONE MAMINDO 31. Date filed (Month, Day, Year)

DHIVIH 17 Rev 1/2001

State

Registrar

ORIGINAL

was it foods

			For State	State of Man				d Mental Hygi	000-	05:36
			Registrar 1. Decedent's Name (First, Middle, Las.)		Cer	tificate c	of Death		g. No 2005	251/6
П	Physici /Medio		Mr. Frank George	,				2. Date of Death	Day 2005	3. Time of Death 3:00P M
,	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town	n, or Location of De	eath	4c. County of Dea	th
			Mariner Health at	North Arur	nde1	Glen I	Burnie		Anne Arun	ide1
	Funeral Director		5. Social Security Number 6. Se 216-40-2109	x 7. Age (i	In yrs. last birthday) 91 Yrs.	If Under 1 Ye Months Da		Irs. 8. Date of Birth (Month, Day, July 9,		hplace (State or Foreign buntry) hoslovakia
	pu »		Usual Residence of Decedent							
	anyla ehov	٦	10a. State 10b. County		Oc. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🙀 No
	28a-1	Director	MD Anne 10e. Street and Number	Arunde1	Glen Burn	10f. Zip Cod				21
	with with	급	806 Oakwood Road			2106		10	og. Citizen of What Co USA	ountry?
	ne 23	Funeral	11. Marital Status	12. Was Decedent Eve	er in U.S. 13. V			(Specify Yes or No- lerto Rican, etc.)	14. Race - Ame	nican Indian.
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelih and Mental Hygiene. Department of Heelih and Mental Hygiene. The fure!, or iteme 23 eor 28a-f show proprient: if item 27 is marked other then "neture!, or iteme 23 eor 28a-f show eny injury or other treumatic event, the Medical Exeminant he notified at ODGs.	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Yes, specify C		erto Rican, etc.)	Black, Whit	
ŏ	2 ho	ted	15. Decedent's Edi		16a. Deced	lent's Usual Oc	cupation	1	6b. Kind of Business	Industry
215	thin 7	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	NOT use re	ne during most of tired)	working		
2	ed wi	S		5	Serv	ice Man			Engineeri	ng
<u>n</u>	d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's h	Name (First, Middle, N	faiden Sumame)	
<u> </u>	i Men Marke	P	Frank Stepanek				Unkr			
Z Z	12 st h and 7 ts n treun		19a. Informant's Name/Relationship (T)					Rural Route Number,		
o,	1 and Heeli 1 em 2	1	Mrs. Libuse Stepa 20a. Method of Disposition		20b. Place of Dispo- cemetery, cren			len Burnie	90c. Location - City or	
<u>o</u>	ages ant of t: If it y or c		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify,	Tellioval Itolii State			Aug	ust 2, s	tevensvil]	
Baltimore,	artme ortan injur		21. Signatura Fine Serve Licens	×0	Chesapeak		ation 4 dress of Facility	005		
B	Ped Personal		1/1/		M01411 Si	ngletor	n Funeral	Home, P.A Glen	. 1 Second	L Ave SW
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the	e death. Do not ente	er the mode of	tying, such as card	liac or respiratory arre	st,	Approximate Interval Between
100	Physician		Immediate Cause (Final disease or condition	R	1011	0/	Can			Onset and Death
A. C. C. C.	/Medical		resulting in death)	Due to (or as a c	onsequence of):					7 2 2 2 1 2 1
Е	Examiner		Sequentially list conditions.	b						
X	Sit 9d	iner	Sequentially list conditions, if any, loading to in resolute cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a o	onsequence of):					
1	and and Il-tran	Examin	that initiated events resulting in death) Last	c Due to (or as a c	onsequence of):					
8760,	icate be executed physicien and s the burial-transit	ai								
687	ificate g phy: ss the	edicai		0.						
ŏ	eath certifi ettending p I for use es	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date of del	ivery
Division of Vital Records, P.O. Box	death	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 [4 Pregnant at time		Ectopic pregna Other (specify,			Month	Day Year
0	that the de ned by the e detached f	hys.	9 🗆 Unknown	9□ Unknown						
Ś	8 6 6	þ	Part II. Other significant conditions co	ntributing to death but r	not resulting in the ur	nderlying cause	given in Part I.		acco use contribute to	
oro	w require been si should t	Completed						- 1 Ye	s 2□No 3□Pr	obably 4 Unknown
Sec.	e law has b	npie						24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
<u> </u>	r: The licete ha							perform 1 ☐ Yes 2		2□ No
<u> </u>	iding Physician: Th th. : After this certificete i funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			OH 4	Death (Check only one	V.	
ō	Phys rthis raldi	5	1 Yes 2 No 27. Manner of Death	1 Inpatient 28a. Date of Injury	2 ER/Outpatien	3 DOA	Nursing	Home 5 Resider		cify)
on	ding th. Afte	盲	1 Natural 5 Pending 2 Accident investigation	(Month, Day Y	ear) Injury		njuryat Work? ☐ Yes 2 ☐ No	200. 2000100 1101	w injury occurred	
S	f or Attending Physician: after death. Director: After this certifice I in by the funeral director, p	Certification;	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	- At home, farm, stre			28f. Location (Str.	eet and Number or Ru	ıral Route Number,
ā	ospitat or A hours after uneral Dire ly filled in by	ert	4 Homicide determined	building, etc. (Specity)			City or Town,	State)	
	To the Hospital or All within 24 hours after or To the Funeral Direc completely filled in by	Medical (29a. Certifier (Check only one) Certifying Phy	sician: To the best of ner: On the basis of ex	:amination and/or inv	occurred at the restigation, in m	time, date and pla y opinion, death or	ace, and due to the cal courred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	o the	Mec	29b. Signature and title of certifier	and manner states	J.	29c. Lice	ense number	29	d. Date signed (Mont	h. Day, Year)
	⊢s⊢ŏ		luraro.	Solo te	40	02	7938			
•	3		30, Name and address of person who co	ompleted cause of deat	h (Item 23a) (Type. I	Print) /			,	
	_		Moyer Go.	-60Ty, a		1/90	a a Goot R	-J. Glea.	Burnie M	2005
	Sta Registr	_	31. Date filed (Month, Day, Year) AUG 0 2 2005	2. Registrar's	Signature	~				

Patient Known as Mureay SLATEN Baltimore. Maryland 21215-0036

		1 - For State Registrar	Olale Ol IV		ertificate of	Health and N f Death		eg. N2 0 0	5 25177
Physic	sian	1. Decedent's Name (First, Mic	ddle, Last)				2. Date of Dea Month		3. Time of Death
/Med		MURRAY			LATKIN		July		11:40 AM
Exam	iner	4a. Facility Name (If not institu	11.7			or Location of Death		4c. County of	
		5. Social Security Number	6. Sex 7. A	ge (In yrs. last birtho	BALTIM av) If Under 1 Yea		8. Date of Birth	, 9	N/A Birthplace (State or Foreign
Funera Directo		214-01-9832	1 ∆ M 2□ F	100 Yrs	Months Days		06/06/1	905	Country) NY
and *		Usual Residence of Decedent 10a. State 10b. Cour	ntv	10c. City, Town o	r Location				10d. Inside City Limits
Marylan -f show	to		TIMORE	BALTI					1 Tes 2 No
h the	Director	10e. Street and Number			10f. Zip Code		1	log. Citizen of Wha	at Country?
th wit	al D	2923 WOODVAL	LEY DRIVE		2120	8		U.S.A.	
r dea	Funeral	11. Marital Status	12. Was Deceden Armed Forces	?	3. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No- Rican, etc.)		American Indian, White, etc.
be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "naturel", or Items 23e or 28e-f show avent, I'm Moultal Ere i iner mast be notified at	by	1 ☐ Never Married 2 ☐ M 3 🛣 Widowed 4 ☐ Divord	larried 1 Tyes 2 1	No	1 ☐ Yes 2 🛣 No			Specify:	WHITE
72 hours "natural",	Completed	15. Deced	lent's Education hest grade completed)	1 (6	ecedent's Usual Occi	e during most of work	king	16b. Kind of Busin	ness/Industry
be filed within 72 hartaf Hygiene. Id other then "netu	ldm	Elementary/Secondary (0-12		(5+) /ii	e. <i>DO NOT use retir</i> SIDENT	red)		FFI MOD (CORPORATION
filed Hygie than than	ပိ	17. Father's Name (First, Midd	le, Last)	INL	SIDENI	18. Mother's Nam	e (First, Middle,	Maiden Sumame)	ONFORATION
id be lental kad c	To B	HYMAN		SLAT	KIN	ROSE		(GOLDMAN
should and Men s marka	-	19a. Informant's Name/Relation	onship (Type, Print)		·	et and Number or Rui	rai Route Numbe		
and 2 ealth a m 27 is		ROBERT SLATK	IN / SON		3 MELODY	LANE BAL	TIMORE,	MD 21208	
Pages 1 nent of He int: If iten ury or oth		20a. Method of Disposition	n 3 □Removal from State		sposition (Name of crematory or other pl	lace)	Date	20c. Location - Cit	ty or Town, State
Pag tment tant:		'4 □Donation 5 □ Other	(Specify)	HAR SIN				OWINGS MI	
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic avant, II a Ma		21. Signature of Funeral Servi	ce Licensee			ress of Facility SOL			S., INC. E, MD 21208
		23a. Part1. Enter the disease,	or complications that cause						Approximate
		shock, or heart failure. L Immediate Cause (Final	ist only one cause on each	line.	71 /	, , ,	, , , , , , , , , , , , , , , , , , , ,		Interval Between Onset and Death
Pnysiciar /Medica		disease or condition resulting in death)	a. Due to (or a	s a consequence of).	hade				Iday
Examine		Sequentially list conditions	Assom	ind April	¿ Anews	ym			2 years
D H	Iner	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying	Due to (or a	e a consequence ofy					
recuted and I-transit	xamln	Cause (Disease or injury that initiated events resulting in death) Last	C. A Due to (or a	s a consequence of)					
be ey ician buria	a E		500 15 (6) 2	s a consequence or,					
ficate physics the	adlc		d						
eath certificate be exattending physician for use as the burian	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom					23d. Date of	of delivery
ne death the atte	Physician/Medical	in the past 12 months? 1 □ Yes 2 □ No		2 Fetal death at time of death	3 □Ectopic pregnan 5 □ Other (specify)	icy		Month	Day Year
that the de ad by the detached	hys	9 🗆 Unknown	_						
res tha iigned	by	Part II. Other significant cond	V(1)		e underlying cause g	given in Part I.			ute to the cause of death?
w require been sign	eted	Coronon ,	.)	case			1 🗆 Y	es 2 No 3	☐ Probably 4 ☐ Unknown
e law has b	Completed	Deventicali	16				24a. Was a autops perfor	sy prio	re autopsy findings available in to completion of cause of the
ysician: The is certificate hadirector, page							1 ☐ Yes	2 № No 1 □	Yes 2 No
sicial certi	o Be	25. Was case referred to med examiner?	Hospital:	tient 2 ER/Outpa	toot 30 004 0	ther	th (Check only or	ence 6 ⊡Other	(Casati)
iding Phys th. After this funeral di	-	27. Manner of Death	28a. Date of Indiana		e of 28c. Inj	ury at		ow injury occurred	(Ѕреспу)
ath. r: Afte	atio	1 ■Natural 5 □ Per 2 □ Accident inve	iding (Month, D estigation	a <i>y Year)</i> Inju	,	ork? □Yes 2□No			
r Atta ter de iracto irby th	Certification:		ald not be 28e. Place of la building, 6	njury - At home, farm etc. (Specify)	street, factory, office	9	28f. Location (S. City or Town	treet and Number on, State)	or Rural Route Number,
pital c		Contillation of Contillation							
To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 Certifier (Check only one)	ying Physician: To the bes al Examiner: On the basis and manner s	of examination and/o	eath occurred at the r investigation, in my	time, date and place, opinion, death occur	and due to the c red at the time, d	ause(s) and manno ate and place, and	er as stated. I due to the cause(s)
To th within To th comp	Me	29b. Signature and tire of cert	ifier	// ~		nse number		9d. Date signed (A	
4		1	Jermit	DV \	HO	062870		July 25	5 7005
10		30. Name and address of pers		death (Item 23a) (Ty	pe, Print)	Hospital o	+ Race	MOVE	

DHMH 17 Rev 1/2001

State

Registrar

Francis C Denuth Jv. Do

31. Date filed (Month, Day, Year)

32. Registrar's Signature

AUG 0 2 2005

			1 - For State Registrer	State of Ma	-	partmer ertifica			ind Ment		ene	15	25178	
	Physici /Medic		1. Decedent's Name (First, Middle, Last, FRANK W.	SHIRK	-)			J	ate of Death Jonth	Day 29	Year 5	3. Time of Death	
	Examir Funeral	ner	4a. Facility Name (If not institution, give JOHNS HOPKIN 5. Social Security Number 6. Sex	SBAYVIE	(In yrs. last birthd	ay) If Under	ACT r1Year	Location of	26 M 24 Hrs. 8. Da Min. 8. Oa	ate of Birth	Ye. 1	TIMO	ace (State or Foreign	
	Director	ctor	201-24-0008 Usual Residence of Decedent 10a. State 10b. County	7.5	73 Yrs.					0, 1932	1932 PA.			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturet", or items 23a or 28a-f ehow any fijury or other traumatic event, the Medical Examiner must be notified at ORGE.										0d. Inside City Limits 1 ☐ Yes 2 🛣 No			
		ai Dire	7850 St. Fabian Lane				p Code 21222			0g. Citizen of What Country? USA				
Maryland 21215-0036		To Be Completed by Funeral Director	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	ver in U.S.	ar in U.S. 13. Was Decedent of Hispanic Origin? (Specif If Yes, specify Cuban, Mexican, Puerto Rin					s or No- 14. Race - American Indian, Black, White, etc. Specify: White				
			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years 15. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Steel Worker							16b. Kind of Business/Industry Bethlehem Steel				
			17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)						t, Middle, M	le, Maiden Surname)				
Mary			19a. Informant's Name/Relationship (Ty Phyllis Shirk						r or Rural Rou ne, Dui		-		Code)	
Baltimore,			20a. Method of Disposition 1 XBurial 2 Cremation 3 F 4 Donation 5 Other (Specify)	emoval from State	20b. Place of Di	sposition (Na crematory or	me of other place) A	ugust 2	2,	Oc. Location	- City or Tov		
Balti			21. Signature of Funeral Service Licens	onne	lly	Conne.	nd Address lly F Solle	s of Facility unera rs Po	l Home	Of Di	undalk undalk	P.A.		
	Physician /Medical Examiner	ıer	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause. (Disease or injury that initiated events resulting in death) Last Onset and De CARDIAC ARREST Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									Approximate Interval Between Onset and Death		
.O. Box 68760, 🛆	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours alter death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Certification; To Be Completed by Physician/Medical Examiner												
			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown							23d. Date of Month			delivery Day Year	
rds, P			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								o use contribute to the cause of death? 2 No 3 Probably 4 Unknown			
of Vital Records,			CHRONIC OBSTRUCTIVE PULMONARY DISEASE 24a. W au au 10 Yes							4a. Was an autopsy perform	sy prior to completion of cause of			
f Vita			25. Was case referred to medical examiner?	26. Place of Death (Check only one) Hospital: 1 Unpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)										
			27. Manner of leath 1 Natural 5 Pending 2 Accident investigation						28d. D	28d. Describe how injury occurred				
Division			3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	of Injury - At home, farm, street, factory, office g, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
			29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
		Me	29b. Signature and title of certifier	110	M	29	c. License	number	2000	41/29	d. Date signe	d (Month, D	ay, Year)	
	10		* Kobert Duhaney M AF-2664200046 07/29/05 30. Name and address of person who completed cause of death (Nem 23a) (Type, Print) ROBERT DUHANEY 4940 EASTERN AVE. BALTIMORE, MD 21224											
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 2 20	32. Registrar	's Signature	Specie	,	**		., - , ,				

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Angel Simms 05-04943 **RJD** Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY 22, Day 2005 Year Physician 0155 A. M Angel Lynn Simms /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore 5. Social Security Number Il Under 1 Year Il Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) 1 M 2 NF Director 220-98-7129 $23 \frac{26}{}$ 05-19-1982 Maryland Usual Residence of Decedent should be filed within 72 hours after deeth with the Maryland 10a State 10b. Count 10c. City, Town or Location Item 27 is marked other than "natural", or Items 23a or 28a-f ahow other traumatic event, the Modical Examinar must be notified at 10d. Inside City Limits Director 1 Yes 2 No Md N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4806 Lonelly Ave 21224 Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) at Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 11 Cashier Food Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental George Leon Simms Joanne Williams ..ormit. Pages 1 and 2 sho.
Depertment of Heelth Important: If Herany Injury any Injury -19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Williams 2037 Ellsworth Street Baltimore, Maryland 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 07/30/2005 Baltimore, Maryland 4 Donation 5 □ Other (Specify) Trinity Cemetery 21. Signature of T neral Service Licensee 22. Name and Address of Facility Wise Funeral Services, P.A. 700 S. Beechfield Ave Baltimore, Maryland 21229 Mis 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) Due to (or as a or isequence ol): /Medical Examiner Sequentially list conditions, flam, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Dina to (or as a consequence of) The faw requires that the death certificate be executed burial-transit that initiated events attending physician and for use as the burial-traresulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. Il yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of de_th?

1 AV es 2 □ No 24a. Was an page 2 has certificate 1/D Yes 2 No or Attending Physician: 25. Was case referred to medical examiner?

1 \(\text{Yes} \) Yes 2 \(\text{No} \) Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA funeral 28a. Date of Injury (Month, Day 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury Found M inct and 1 ☐ Yes 2 No Fourd Frelo 2 Accident filled in by the Director 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide bonelly Avenue To the Hospital within 24 hours e To the Funeral I 0 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2X Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certified 29c. License number July 22, 2005 Ó address ol person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore Maryland 21201 THE VIENT MIKER 31. Date liled (Month, Day, Year) 32. gistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2005

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			AMEND ITEM #19		Maryland / i				nd Mental	Hygie Reg.	201	15	251	90			
		1. Decedent's Name (First, Middle, Last) Physician TM AR CARET					THUBOT					Year	3. Time o	f Death			
1	/Medi Examii		4a. Facility Name (If not institution	n, give street and number		,, ,,			, or Location of	Death	4c. County		7				
			Haven Nursing Home					Baltimore			N/A						
	Funeral Director		5. Social Security Number 219–18–8042	6. Sex 7	Age (In yrs. last bii 80	thday) If Under Yrs. Months			Min. 8. Date (Mont)	of Birth Day 0-19	25	9. Birthpl Count	ace (State	or Foreign			
	ith with the Maryland 23a or 28a-f show	ō	Usual Residence of Decedent 10a. State 10b. County MD N / A		10c. City, Tow Balti							10	10d. Inside City Limits 1 X Yes 2 □ No				
	r 28a-	Irect	10e. Street and Number 10f. Zip Code							10g.	Citizen of W	Vhat Count					
	th wit	al D	1010 W. Baltimore St. 21223					23			U.S.	Α.					
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "netural", or items 23a or 28a-f show important: if item 27 is marked other than "hetural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married ② Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ YNo If Yes, Give Year or Dates:		13. Was Deced If Yes, spec	ify Cuba	ispanic Origin n, Mexican, F Specify:	? (Specify Yes o Puerto Rican, etc	Rićan, etc.) B			lace - American Indian, clack, White, etc.				
Maryland 21215-0020		Completed	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give k life. D				dent's Usual Occupation kind of work done during most of working DO NOT use retired)					16b. Kind of Business/Industry					
		ပ္	12 Home maker Dome 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surna							estic							
		To Be	Edward Mol			ra Mol											
Aary	2 short and he is main		19a. Informant's Name/Relations	G037	196	. Mailing Address	(Street a					State, Zip	Code)	7			
_	s 1 end of Health item 27 other tr		Melvin Talbot 20a. Method of Disposition	t (spouse)	20b. Place of	027 Cat Disposition (Nam	e of		t. Bal								
Baltimore,	permit. Pages Department of I Important: If ite any injury or o		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Cem. 8-4-05 Owings Mill MD														
Balt			21. Signatur of Funeral Service License Estep Sr. (Supplemental Service P.A. 1300 Eutaw PL. Baltimore MD 21217														
П			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus	ed the death Do	not enter the mode	of dying	g, such as car	rdiac or respirate	IIIO I'e	. עוא		Approximat Interval Bet	ie ween			
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. ac	ute	Res	bé	sati	ر کرد	ja	ilu		Onset and I				
14	The law requires that the death certificate be executed ate has been signed by the attending physician end page 2 should be detached for use es the burial-trensit	edical Examiner		K	Due to (or as a	consequence of:	F	ail	lun	ρ		į					
			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Consequentially list conditions, if any, leading to immediate cause. Enter Underlying														
68760,			that initiated events resulting in death) Last Due to (or as a consequence of):														
Вох	eath certifi attending I for use es	Physiclan/M	a Ceronary artery District														
P.O. I	that the dea led by the at detached fo	ysic	Part II. Othar significant conditio	ns contributing to death	but not resulting in	the underlying ca	use give	on in Part I.	23b.	Did tobac	co usa con						
s, P	es that igned by be deta	by Ph								Unknown							
of Vital Records,	aw require as been sig 2 should b	Completed	A Completion of cau								.0						
a B		o Be								1 🗆 Yes	24 Ro	1 🗆	Yes 2□	No			
Zit.	Physicien: this certific		25. Was case referred to medical examiner? 1 Yes 2 400	Hospital:	ient 2 EP/Ou	tpatient 3□ DOA	Othe		Death (Check o		. □ O++-	. (0%)					
on of	To the Hospital or Attending Phywwthin A hours died deeth. To the Funeral Director: After this completely filled in by the funeral d	Itlon: T	The state of the														
Division		ertifica									Route Num	ber,					
		edical C	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)														
	Vithii To th	ž	29b. Signature and title of certifier	1		29c.	License	number	3	29d. [Date signed	(Month, D	ay Year)				
		-	P of	worl-a	car	1) 1	DO	3/9	105	1	12	9/	20	01			
	1	\	30. Name and address of person v	uno completed cause of	reath (Item 23a) (Type, Print)	31/	MULL	flant o	ary	BAR	10	41/2	12/5			
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature														

<i>31</i> 0		1 - For State Registrar	State of Mary	-	artment of <i>rtificate o</i>			ene	15 251	81
Physi	cian	Decedent's Name (First, Middle, Last Robert)		Tabb		2. Date of Death Month	Day	3. Time of [
/Med Exam		4a. Facility Name (If not institution, give			4b. City, Town	or Location of De	July 23	4c. County o		P [™]
, Funera Directo		5. Social Security Number 6. Se 216–36–3287 10 Usual Residence of Decedent	**	yrs. last birthday) 65 Yrs.	If Under 1 Year Months Day			Year)	9. Birthplace (State or Country) La.	Foreign
Maryland	ctor	10a. State 10b. County Md.	N A 10	c. City, Town or Lo	Baltimor	e			10d. Inside City	,
with the	Dire	10e. Street and Number 1516 N. Eden	Strret		10f. Zip Code	21213	10	g. Citizen of WI	-	
ING 21213-UU36 be filed within 72 hours after death with the Maryland ital Hygiene. d other than "naturel", or iteme 23e or 28e-f ehow event, the Madical Examiner must be notified at	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	in U.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin? Iban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race	- American Indian, White, etc. Black	
d within 72 giene.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12th grade		(Give	dent's Usual Occ kind of work dor DO NOT use reti Labor	e during most of w red)	vorking	6b. Kind of Bus Var	,	
	To Be (17. Father's Name (First, Middle, Last) Julius		Tabb		1	^{ame (First, Middle, M} Charlene		Glaze	
		19a. Informant's Name/Relationship (T) Delores Epps	ype, Print) Sister—In—la	201			Rural Route Number, Baltimor		tate, Zip Code) 21218	
Page nent o		20a. Method of Disposition 1 □ Nourial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State		osition (Name of matory or other p mel Cen	' I	1-05	Dunda	ity or Town, State	
permit. Deperting		21. Signature of Funeral Service Licens	ech		2. Name and Add March F	ress of Facility .H. East	Baltimor : 1101 F	e, Md.	21202	
Physiciar /Medica Examine	il r ≫ા_	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	EUSIUE AT nsequence of):			DIOWASCUL		Approximate Interval Betwi Onset and De	reen
cate be executed oblysician and the burial-transit	dical Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co							
death certifi e attending I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	33c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnan Other (specify)	су		23d. Date Monti		ear .
v requires that the been signed by th should be deteche	þ	Part II. Other significant conditions co			nderlying cause o	oven in Part I.	1 ☐ Yes	2 XNO 3	ute to the cause of dea	
The lav	e Completed	25. Was case referred to medical					24a. Was an autopsy perform Yes 2	ed? de □No 1	ore autopsy findings av or to completion of cau ath?	vailable use of
Physicien: this certific ral director,	To B	examiner?	lospital: 1 Inpatient	2 X ER/Outpatier	it 3 DOA	thor	eath <i>Check only one</i> Home 5 Resider		(Specify)	
Attending Pl		27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	W	uryat ork? ⊒Yes 2 □ No	28d. Describe how	v injury occurred	I	
To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, str pecify)	eet, factory, office	•	28f. Location (Stre City or Town,		or Rural Route Numbe	Θ <i>Γ</i> ,
he Hospitel n 24 hours a he Funeral I	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☑ Medical Exemi	sicien: To the best of my ner: On the basis of exa and manner stated.	knowledge, deatl mination and/or in	occurred at the vestigation, in my	time, date and pla opinion, death oc	ce, and due to the cau curred at the time, dat	use(s) and manr e and place, an	ner as stated. d due to the cause(s)	
To the within 2 To the complet	×	29b. Signature and title of centries	(In			nse number CME		d. Date signed (July 24	Month, Day, Year) , 2005	
2'		30. Name and address of rerson o co	ted use of death	(Item 23a) (Type,	Print) 111 I	Penn Stre	et Baltin	nore, Ma	ryland 212	201
S Regis	tate	31. Date filed (Month, Day, Year) AUG (32. Registrar's S	oignature	Local	1				

		For State Registrar	te of Ma	ıryland	-	artment of H tificate of I	lealth and M Death		ene 9. 12. () ()5	25182
Physicia:		1. Decedent's Name (First, Middle, Last) Louis E. Thomas						2. Date of Death Month July		005	3. Time of Death 8:15 P M
/Medica Examine	r	4a. Facility Name (Il not institution, give street a Gilchrist Center				Tows			4c. Count	y of Death Balt	
- Funeral Director		5. Social Security Number 214-40-3621 Usual Residence of Decedent		(In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 31,	1942	9. Birthi Coul Mary	place (State or Foreign Land
aryland 21215-0036 should be filed within 72 hours efter death with the Maryland and Manial Hygiene. marked other than "neturel; or items 23a or 28a-f show unatic event, the Madical Examiner must be notified at	Director	10a. State 10b. County Maryland Harford 10e. Street and Number		10c. City,	Town or Lo	gdon		10	lg. Citizen of		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
eath with	erai Dii	2904 Airdrie Avenue	s Decedent E	ver in 11 S	12 1	210	009		u.	S.A.	
0036 ours elter de rreit, or item	d by Funeral	1 ☐ Never Married 2 ☑ Married 1 ☐ If Y	ned Forces? Yes 2 X N es, Give ar or Dates:			Yes, specify Cuba	ispanic Origin? (Spin, Mexican, Puerto Specify:	Rican, etc.)		ick, White,	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel; or items 23s or 28s-1 show any njury or other traumatic event, the Macifial Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade comp. Elementary/Secondary (0-12) Col 12th Grade	leted) tege (1-4or 5-	+)	(Give	lent's Usual Occupa kind of work done of DO NOT use retired Estate B	during most of work f)	ing 1	66. Kind of E Real		
rland	To Be C	17. Father's Name (First, Middle, Last) Ernest Thomas					18. Mother's Name Eleanor		aiden Suma UMAN	me)	
Mary nd 2 shou alth and M 27 is mai		19a. Informant's Name/Relationship (Type, Pri. Mrs. Ellen Thomas	wife)			_	and Number or Rura AVENUE,		•	, State, Zip	
MOCE, Pages 1a ent of He nt: if item		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	I from State			sition (Name of natory or other plac oh. Ch., Ce	m. 8/2/2		Oc. Location	-	
Baltin permit. Deportm Importer any nju		21. Signature of Funeral Service Licensee	Sinch	2	22	. Name and Addres	ir Rd., B	imunek F	unera		es
Physician /Medical		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death)	that caused to on each line Stoke k	e.		er the mode of dying	g, such as cardiac o	or respiratory arre	st,		Approximate Interval Between Onset and Death
8760, (5) cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	oue to (or as a	conseque	ence of):						jans
I Records, P.O. Box 68 I Records, P.O. Box 68 The law requires that the death certifica ste has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	in the past 12 months?	es, outcome o Live birth 2 Pregnant at t Unknown	2 Fetal o	death 3 🗌	Ectopic pregnancy Other (specify)			1	ate of delive	ery Day Year
rds, P quires that n signed that	2	Part II. Other significant conditions contributing	ig to death bu	t not resul	ting in the un	derlying cause give	en in Part I.	23e. Did toba	_		ne cause of death? pably 4 □Unknown
of Vital Records, physician: The law requires this certificate has been signed at director, page 2 should be or	Completed							24a. Was an autopsy perform	ed?	Were auto prior to co death? 1 Yes	psy findings available mptetion of cause of
on of aling Physical Alter this funeral di	ation; lo Be	25. Was case referred to medical examiner? 1 Tyes 2 No Hospital 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatier Date of Injury (Month, Day		P/Outpatien 28b. Time of Injury	28c. Injury Work	26. Place of Death Br. 4 \sum Nursing Ho / at Yes 2 \sum No</td <td></td> <td>100 6 1001</td> <td></td> <td>mospice</td>		100 6 100 1		mospice
Div A alter A Bire by Bire	Certification;	3 Suicide 6 Could not be determined 28e	Place of Inju building, etc.	ry - At hon . (Specify)	ne, farm, stre	eet, factory, office		28f. Location (Stre City or Town,		ber or Rura	l Route Number,
Div Div S Div Div 24 Hours after the Funarel Div mplately filled in Div Div Div Div Div Div Div Div Div Div	Medicai	29a. Certifier (Check only one) Errifying Physician: 2 Medical Examiner: Or an	To the best on the basis of dimanner state	examination	ledge, death on and/or inv	occurred at the timestigation, in my op	ne, date and place, pinion, death occurr	and due to the car ed at the time, da	use(s) and m te and place,	anner as s and due to	tated. the cause(s)
To the within To the Company of the	E	29b. Senature and little of certifier	12			29c. License		29	d. Date signe	3 U	Day, Year)
15		30. Name and address of person who complete	66	01	23a) (Type	harles	57303 St 100	NEW 1	402	1204	
State Registra	-	31. Date filed (Month, Day, Year) AUG 0 2. 2005	32. Registra	r's Signatu	Some!	W.					

			1- For State of Maryland / Dep	artment of Health and Mertificate of Death		ene 9.12.005	25183
	Physici	an	Decedent's Name (First, Middle, Last) KATHARINE CLAIRE TILGHMAN		2. Date of Death Month JULY	Day 2005	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	JULI	4c. County of Deat	1 22
			1805 HILLENWOOD ROAD	BALTIMORE		N/A	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 DT 7. Age (In yrs. last birthday 82 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 12/21/	Year) 9. Birli Co 1922 MA	nplace (State or Foreign untry) RYLAND
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	a-f sho	ctor	MD N/A BALT	IMORE			1X Yes 2 □ No
	with the	Director	10e. Street and Number 1805 HILLENWOOD ROAD	10f. Zip Code 21239	10	g. Citizen of What Co	•
	death ms 23	Funerai		Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	USA 14. Race - Ame	ncan Indian,
9	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or Items 23s or 28s-f show event, the Medical Exam are must be indiffed at	by Fu	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 🕅 No Specify:	rican, etc.)	Black, White Specify:	e, etc. WHITE
12-0036	72 hour		15. Decedent's Education 16a. Dece	edent's Usual Occupation a kind of work done during most of worki	ing 1	6b. Kind of Business/	ndustry
	filed within 72 Hygiene. other than "nate ont, the Medic	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) OMEMAKER	ing .	HOM	E
שנ	be filed ital Hygie d other	a l	12-th_GRADE 17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, M		
ylan		To B	ANDREW THUMSER		BROWN		
Na	2 6 6 6	1 5	1	ing Address (Street and Number or Rura 8 BROOK MEADOW DRI		City or Town, State, 2 ON MD 212	
ore,	of Health If item 27 or other tra		20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition complexy, creation of the complexy of the complexy of the complexy of the complexy of the complexy of the complexy of the complexy of the complexy of the complexy of the complexy of the complexy of the complexy of the complexy of the complex of the comple	osition (Name of Ematory or other place)	Date 2	Oc. Location - City or	Town, State
Baltimore,	permit, Pages Department of I Important: If Ite any injury or or once.	. 1	'4 □Donation 5 □Other (Specify)	VALLEY MEM. 8/3/0		OCKEYSVILL	
ä	permit. Departr Importa any inju			8521 LOCH RAVEN BL		N FUNERAL . SON, MD 21	
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	//			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	BREAST CAR	HOME	4-	2002.
	Examiner						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
Ď,	icate be executed physician and s the burial-transit	і Еха	resulting in death) Last Due to (or as a consequence of):				
09/89	death certificate be executed e attending physician and of for use as the burial-transit	edicai	d	m			
XOD	eath certific attending p I for use as I	an/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy		23d. Date of deli	
5	that the dea ted by the at detached fo	Physician/M		Other (specify)		Month	Day Year
S, T	requires that een signed by hould be deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	anderlying cause given in Part I.		acco use contribute to	the cause of death?
cora	w require been si should t	eted	SOVAMOUS CEIL CARCINON	IN OF THE		s 2 No 3 □ Pro	
al Kec	The la ete has page 2	Completed	MOUTH; HYBERTENSION	TY DOT WYROLD	24a. Was an autopsy perform	ed/? death?	topsy findings available ompletion of cause of 2 No
<u> </u>	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death ant 3 DOA Other: 4 Nursing Hor	. /	nce 6 □Other (Spec	ifu)
n of	ing After Unel	on: T	27. Manner of Sah 28a. Date of Injury 28b. Time (Month, Day Year) Injury	of 28c. Injury at Work?	28d. Describe how		,,
JIVISION	Attending or death.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury, - At home, farm, st	M 1 ☐ Yes 2 ▼No	28f. Location (Stre	eet and Number or Ru	ral Route Number,
5			4 ☐ Homicide determined building, etc. (Specify)		City or Town,		
	To the Hoapitat or within 24 hours after To the Funeral Discompletely filled in	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea a control of my knowledge, dea and manner stated. 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a restigation, in my opinion, death occurr	and due to the car red at the time, dar	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Moglifi	, Day, Year)
	N	Ŋ	30. Name and address of person who completed cause of death (Item 23a) (Type	D D2533/	a 10.	No/1/2	16 311
Ú			BAIC FISHER MID.	TOWEO,	es au	2128	54.
	Sta Registr		31. Date filed (Month, Pay, Year) AUG 0 2 2005	34/12			

			1 - For State Registrar	State of Mar	-	epartmen Certificat				_	giene Reg. N2	nn =	2510) [.
			Decedent's Name (First, Middle, Last)							2. Date of De	ath		3. Time of D	Death
	Physici /Medio		DOLORES		TIC	E				Month	Day	۲۰ ک ک		PM
	Examin		4a. Facility Name (If not institution, give s	street and number)				Location of			4c.	County of D		
	o .			HUSPITAL				HUS 7					IMURE	
	Funeral Director		5. Social Security Number 6. Sex 1213 30 6478		(In yrs. last birth 73 Yr	Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Oct. 2	th l <u>y,</u> Year)	9. 221 N	Birthplace (State or a	Foreign
			Usual Residence of Decedent							Oct. 2	/ , I	931 1	Maryland	
	nylanc how		10a. State 10b. County	1	Ioc. City, Town	or Location							10d. Inside City	Limits
	80-1 s	Director	Maryland Baltimo	re	Reist	terstown	n						1 ☐ Yes 2	≧ I No
	or 20	Dire	10e. Street and Number			10f. Zip					_	zen of What	Country?	
	s 23s	rai	206 Cantata Cou				211					J.S.		
980	perrait. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than *neturel', or items 23a or 28e-f show any njury or other treumetic event, the Medical Examiner must be mailined at once.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	er in U.S.	13. Was Deced If Yes, spec			gin? (Spe i, Puerto I	cify Yes or No Rican, etc.)			merican Indian, /hite, etc. Vhite	
2-0	72 ho	ted	15. Decedent's Edu		16a. D	ecedent's Usua	I Occupa	ation	t of working		16b. Kir	nd of Busine	ess/Industry	
21	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		Give kind of wor ife. DO NOT us		iuring mosi)	t of workii	ng		· · · ·		
12	led w lygier her th		12th		по	memaker						Own Ho	ome	
Baltimore, Maryland 21215-0036	buld be fi Mental H arked of	To Be		st McCarthy				A	Alvir	(First, Middle, na Anna	Mace	ek		
, Mar	is 1 and 2 shift Health and item 27 is mother treum		19a. Informant's Name/Relationship (Ty) Edward Hatfield /			Mailing Address Vivian V							_{e, Zip Code)} cyland 211	.33
ore	of He	1	20a. Method of Disposition 1 ™ Burial 2 □ Cremation 3 □ R	emoval from State	20b. Place of D cemetery,	isposition (Nan crematory or o	ne of ther place	θ)	D	ate			or Town, State	
Ë	ment tent: Jury c		*4 □Donation 5 □Other (Specify)	Simotal Home States	MD Stat								le, Maryl	and
Bal	Departition Depart		21. Signature of Funeral Service License	emualy	h								ice, P.A. ryland 21	225
	Physician		23a. Part1. Enter the disease or complishock, or heart failure. List only on Immediate Cause (Final	ne cause on each line.				ν.			rrest,		Approximate Interval Betwee Onset and De	
П	/Medical		disease or condition resulting in death)	Due to (or as a	consequence of)	gonve pa	psi	<i>a</i>					1 de	ay
ŧ.	Examiner		Sequentially list conditions	Due to (or as a c	ardiopu	elmona	~	Ma	em	i			1 de	
	sit ad	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a d	conseque e of)	:	J	6						9
_	icate be executed physician and s the burial-transit	хаш	that initiated events resulting in death) Last	Due to (or as a c	consequence of)	,			_					
8760,	be exician buria	aiE			Juni304081108 (1)									
687	tificate ig phys as the	edicai	d				-							
Xo	death certificate be executed e attending physician and ad for use as the burial-transit	M/U	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of		- 0-					2	3d. Date of	delivery	
В	that the death ed by the atte detached for	by Physician/Me	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1□Live birth 2 4□Pregnant at tin 9□Unknown		3 □Ectopic pro 5 □ Other (spo						Month	Day Yea	ar
О.	res that the igned by be detact	y Ph	Part II. Other significant conditions con	itributing to death but i	not resulting in th	he underlying ca	ause give	n in Part I.		23e. Did to	obacco us	e contribute	to the cause of dea	ath?
Vital Records,	The law requires that the ste has been signed by th bage 2 should be detache	q pa								1 🗆 Y	∕es 2□]No 3□	Probably 4. Uni	known
000	law requir as been si 2 should	plet								24a. Was		24b. Were	autopsy findings av	ailable
Ä	The lav	Completed									rmed? 2 No	prior death 1 🔲 Y		se of
ita	i clen: Th certificate ector, pag	Bec	25. Was case referred to medical examiner?					26. Place	of Death	(Check only o	-,-	,		
	Physiclen: r this certific ral director,	To	1 ☐ Yes 2 No	lospital: 1 Dipatient	2 ER/Outpa	atient 3□ DO	A Othe	r: 4 □ Nur	rsing Hon	ne 5∏Resid	dence 6	□Other (S	pecify)	
Division of	ding After fune	ation:	27. Manner of Death Natural 5 Pending Accident investigation	28a. Date of Injury (Month, Day Y	(ear) 28b. Tim Inju		3c. Injury Work 1 🗀 Y			8d. Describe h	now injury	occurred		
Divis	l or At after of Direct in by	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm (Specify)	s, street, factory	office		2	8f. Location (S City or Tow		Number or	Rural Route Numbe	ır.
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edicai C	29a. Certifier 1 Certifying Phys (Check only one)	sician: To the best of refer: On the basis of each of manner state	camination and/o	death occurred a or investigation,	at the time in my op	e, date and inion, deat	d place, a h occurre	nd due to the o	cause(s) a	and manner place, and c	as stated. lue to the cause(s)	
	To the within Fo the comple	Me	29b. Signature and title of certifier			29c.	License	number			29d. Date	signed (Mo	onth, Day, Year)	
}_	/.		A wish	mo			D	005	973	6	In	e ?	6 2005	
2	7		30. Name and address of person who con		th (Item 23a) (Ty	/pe, Print)					1	7		
<u> </u>			DESULAH WATIS	M, MD.	No	LTHWEST	r (-	1857 IT.	M	5401	OL	0 (00	AT ROAK	9
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 2 200	32. legistrar's	Signature	foods								

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legibl
--	------------------------------

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Carmella May Towles 10:05AM. ZDOS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye Oct. 22, Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Year) 1 □ M 2 √ F 214-24-6941 76 1928 MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. Count 10c. City, Town or Location 77 is marked other than "naturel", or Items 23a or 28a-f show traumatic event, the Medical Example of most be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6506 Home Water Way Unit 102 21060-3222 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No þ Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be 1 and 2 should be Health and Mental Randolph Thompson Elizabeth Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3222 mportent: if item 27 Mr. John Edward Towles/husband 6506 Home Water Way Unit 102, Glen Burnie, MD 21060-20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 3 Crestlawn Mem. Gardens * 4 ☐ Donation 5 ☐ Other (Specify) Marriottsville, MD 22. Name and Address of Facility Singleton Funeral Home P.A. 21. Signature of Juneral Septemblicensee Second Avenue S.W., Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Subaracha disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit to the Hospitei or Attending Physician: The law requires that the death certificate be executed that initiated events P.O. Box 68760. resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. à 2 No 1 ☐ Yes 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? 2 No Other: 1 Yes 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 2 Accident Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the fu death. 1 Yes 2 No investigation M 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theyen ith, Day, Year) 2. Registrar Signature State AUG 0 2 2005 Registrar

amend item#5, per Nf. G846, 8/9/05 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** July 2005 29 Paul. Bruce Wolfe 5:53 p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Gilchrist Center for Hospice Care Towson If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day JUN 15 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 1 X M 2 □ F 55 Ohio Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Catonsville MD 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21228 3 Hunting Creek Court USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 🗓 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Scientist Research 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Marion Hayner James Warren Wolfe ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 item 27 i 3 Huntin Creek Court, Catonsville, MD 21228 Phuong Wolfe - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 0 <u>=</u> 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ö Department of Important: if any injury or once. 8/4/2005 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory Inc. Beltsville, MD CAFA, Stephen D. Lohrmann, PA 8717 Green Pastures Drive, Towson, MD 21. Signature of Funeral Service Lig ₩00986 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final esophaccal **Physician** ancer montas disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner physician and the burial-transit Due to (or as a consequence of). Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 2 🗀 3 Probably 4 Unknown 1 TYes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 2 No certificate 1 ☐ Yes Hospital or Attending Physician: After this certific funeral director. 25. Was case referred to medical Be 26. Place of Death | Check only one examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) WCFICE ို 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medicai Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 🖳 🚅 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St 6601 ma 31. Date filed (Month, Day, Year) 2005 Register's Signature

DHMH 17 Rev 1/2001

State Registrar

10

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. NR. () () 5 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** Mariarm 26 1755PM Walker 07 05 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner GOOD SAMARITAN LYOSPITAL BALTIMURE Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days Min 1 M 2 XF Director 212-74-0503 Maryland 11/02/1954 Usual Residence of Decedent 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits or then "neturel", or Items 23e or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4903 Palmer Avenue Funeral 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No 1 XNever Married 2 Married land 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: Black þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic 11 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fill and Mental H Be William Walker Gloria Gibson Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if Item 27 is any injury or other treu 4903 Palmer Ave., Baltimore, Maryland 21215 Terra Dortch / Neice Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 08/08/2005 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA **Physician** /Medical Due to (or as a consequence of): Examiner SEIZURES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of): burial-1 Physician/Medical 980 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy ö Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4 Pregnant at time of death 5 Other (specify) of Vital Records, P.O. detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by TRACT INFECTION GASTRIT 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed' certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) I Director: After this d in by the funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 T Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signature and title of cartifier MID 000 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JIMMY W HEVRY BLVD RAVEN 5601 LOCH BALTIMORE, MO 31. Date filed (Month, Day, Year) AUG 0 2 2005 3 Registrar's Signature State Registrar

V

M

WALK

Amend item#19a, perFH, G846, 8/10/05 In State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. N2 0 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Williams 28 300 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7. Age (In yrs. last birthday) If Under 1Year Jenera 5. Social Security Number land 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign S. Carolina **Funeral** Days 1□M 2ØF Months Hours Min. 079-20-4324 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28e-f show other treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Baltimore Be Completed by Funeral Director MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 22-30 USA Ave or Iteme 23a 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be tiled within 72 hours after i Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or ther any injury or other treumatic event. The Medical Ferra ☐ Yes 2 No Yes, Give 1 Never Married 2 Married 1□Yes 2□No Specify: Black Specify: 3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Tom Rabb 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Niece 206. Place of Disposition (Name of cemetery, crematory of other place) Pi Kesville MD 21208 Rd. 4611 Hawksbury 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Cemetery mt. Zion 4 □ Donation /5 □ Other (Specify) lansdowner mb 21. Signature of Funeral Service Licensee Fredhilton Ross tome P.A. once an or the diseas , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, rheart failure. List only one cause on each line. 23a. Part1 Approximate Interval Between Onset and Death show r heart failu Immedia Cause (Final disease or condition resulting in death) **Physician** SVITE /Medical Due to (or as a consequence of): Examiner Saquentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 MNo
9 Unknown 3 Ectopic pregnancy ğ Month Day Year 5 Other (specify) detached 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 🗆 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 2 No 1 Yes 1 Tyes or Attending Physicien: rector, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 25 No Other: 1 Yes Certification: To 1 N npatient 4 Nursing Home 5 Residence 6 Other (Specify) ē 2 ER/Outpatient 3 DOA onte of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural

Accident Injury 5 Pending М 1 ☐ Yes 2 ☐ No investigation within 24 hours efter death

To the Funerel Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the h 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State AUG 0 2 2005 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 0 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 31, 2005 Year **Physician** Helen Margaret Whiteley 1:35PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Copper Ridge Institute Sykesville Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year)
Dec. 10, 1903 **Funeral** 9. Birthplace (State or Foreign Days Hours Min. 1 ☐ M 2 1 F 212-52-7581 101 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b County 10c. City, Town or Location 10a State 10d. Inside City Limits or 28a-f show r then "neturel", or Items 23e or 28a-f shov the Medical Examiner must be notified at 1 Yes 2 No Director Md. Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 725 Snowfall Way 21157 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: White Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other then Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Housewife 6 other traumatic event, perrii. Pages 1 and 2 should be file Deportment of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other traumatic event QREs. Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Franklin Baylis Mary Zito Biebelheiser ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie Conner - Daughter 725 Snowfall Way, Westminster, Md. 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 the Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cem. Aug. 3, 2005 Baltimore, Md. * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funera Service Licensee 22. Name and Address of Facility 21117 Eckhardt Funeral Chapel, P.A. 23a. Part1. Entry the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line.

11605 Reisterstown Rd. Owings Mills Md.

Approximate Interval Between Open and Death Immediate Cause (Final **Physician** Kneumani resulting in death) /Medical Due to (or as a consequence of): Examiner Mocordia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medicai 1/emer1 as the IF FEMALE: esn If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy be detached for in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Probably 4 Unknown page 2 should Be Completed 1 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 1 ☐ Yes 2 No or Attending Physicien: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 ☑No Other: Certification: To 2 ER/Outpatient 3□ DOA ursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident completely filled in by the Director: 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stone Mu 31. Date filed (Month, Day, Year) 2. Registrar's Signature State AUG 0 2 2005 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Reg. No 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2005 July 30, **Physician** 8:15PM Kenneth L. Weir, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 6 Wensley Dale Court Owings Mills If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr. 20, 1 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1**X** M 2□ F 70 Vrs Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel; or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Owings Mills Md. Baltimore 1 ☐ Yes 2 X No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21117 6 Wensley Dale Court U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 □ ¥es 2 □ No 1955— If Yes, Give Year or Dates: 1957 Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White þ 3 ☐ Widowed 4 ☑ Divorced 1957 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Sales Executive Refrigeration 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mabel E. Carr Samuel J. Weir 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Meredith Weir - Brother 6759 Woodley Rd., Baltimore, Md. 21222 20b. Place of Disposition (Name of cometery, crematory or other place) Maryland Veterans Cem. Aug. 4, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 2005 Owings Mills, Ad. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Program Service License 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd., Owings Mills. Do ny enter the mode of dying, such as cardiac or respiratory arrest. 23a. Part / Enter the disease, or complications that c shock, or heart failure. List only one cause on Approximate Interval Between Onset and Death used the deals. nmediate Cause (Final year disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an 2 No 1 ☐ Yes 25. Was case referred to 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home Certification: To 1 ☐ Yes 2 ☑ No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 5 Residence 6 □Other (Specify) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical **Examiner** The law requires that the death certificate be executed the burial-transit Box 68760, the attending physician use P.O. page 2 should be detached signed by Division of Vital Records, or Attending Physicien: funeral director, within 24 hours after death. To the Funeral Director: # the in by t lled To the !

death with the Maryland

Maryland 21215-0036

Baltimore.

Medical

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Oay, Year)

0

4 Homicide

(Check only one)

and title of certifie

29a. Certifier

29b. Signatura

32. Registrar's Signature

1 🗹 Certifying Physician: To the best of my knowledge, death осситеd at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License numbe

29d. Date signed (Month, Day, Year)

				For State Registrer	State of M	Maryland	-	rtment of H		Mental Hy	giene	05	25191
				1. Decedent's Name (First, Middle, Last)						2. Date of D Month		Voor	3. Time of Death
		hysicia /Medica		ERIC WALKER						JULY	31	2005	2:10 A M
	E. E	xamine	er	a. Facility Name (If not institution, give :					Location of Deat	h	4c. Count	ty of Death	
	r.			ST. JOSEPH HOSPIC 5. Social Security Number 6. Sep		R Age (in yrs. la	st birthday)	If Under 1 Year	RE If Under 24 Hrs.	8. Date of B	idh	9 Birtho	lace (State or Foreign
		neral ector			M 2□F	39	Yrs.	Months Days	Hours Min.	(Month, D	ay, Year) 1965	Coun	rry) NC
	put	8		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Loc	ation					0d. Inside City Limits
	Maryla	e pai	ō					2001				,	1 Yes 2 No
	death with the Maryland	1280	Director	MD BALTIMORE 10e. Street and Number		GWIN	N OAK	10f. Zip Code			10g. Citizen of	What Coun	
	th wit	Mat be	a D	2011 ROYAL COURT	DRIVE			21207				USA	
	er dea	Derm	Funeral		12. Was Deceder Armed Forces	s?		as Decedent of Hi Yes, specify Cuba	ispanic Origin? (S ın, Mexican, Puert	pecify Yes or N to Rican, etc.)		ce - Americ ack, White,	
ç	J36 Irs aft	0.10	by	XXNever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes X If Yes, Give Year or Dates	:: K 140	1	☐ Yes 2☐ No	Specify:		Speci	fy: BLA	CK
	2 Pol 2/	lical E	eted	15. Decedent's Edu (Specify only highest grade			16a. Deced	ent's Usual Occupa	ation during most of wor	rkina	16b. Kind of E		
Š	Mithin one.	men .	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life. D	O NOT use retired)				
7	filed v	ant, II		12 17. Father's Name (First, Middle, Last)			SUPER	VISOR	18. Mother's Nar	ne (First, Middle		INSPE	CTOR
!	Maryland 21215-0035 Id 2 should be filed within 72 hours afith and Mental Hygiene.	tic eve	To Be	JOSEPH WALKER, JE	L.				MILDR	ED TOLS	ON	,	
	2 should hand hand h	euma euma		19a. Informant's Name/Relationship (Ty				Address (Street a					Code)
	e, E	ther tr		CYNTHIA W. JOUBER 20a. Method of Disposition	ET	20h Pla		FLEETWO	OD DR. B	ELTSVIL.	-		um Ctata
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.	ury or of		Burial 2 Cremation The Property A Dogation 5 Other (Specify)	emoval from Stat	• NEW	OAK G	atory or other place ROVE CEM	8.6.		ELIZABI	-	
2	Dalt Permit. Depart	any inj		21. Size fure of Funeral Service License	0 -	401148		Name and Address NK FUNER 6 CRAIN I			NTE MIN	21061	
				23a. Part1. Enter the dispase, or compleshock, of heart failure. List only of			Do not ente	r the mode of dying	g, such as cardiac	or respiratory	arrest,	21001	Approximate Interval Between
		ician		Immediate Cause (Final disease or condition	A	123	5						Onset and Death
26		dical niner		resulting in death)	Due to (of a	is a conseque	ence of):						/
14			Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause University and the cause of killing	Due to (or a	is a conseque	ence of):						
18	cuted	and	Examine	that initiated events									
10 8	50°,	burial-transit	E	resulting in death) Last	Due to (or a	is a conseque	ence of):						
05	OS/60	the i	edical										
	BOX (use a	by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcom	e of pregnan					23d. Da	ate of delive	гу
3	death	ed for	sicla	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	at time of dea		Ectopic pregnancy Other <i>(specify)</i>			M	onth	Day Year
1	r hat the	d by the fetach	Phy.	9 ☐ Unknown Part II. Other significant conditions cor			ting in the un	dorhing onues give	on in Bort I	230 Did	tobacco use con	stributo to th	a cause of death
, 4	RECOTGS, P.O. BOX 68/60, The law requires that the death certificate be executed			artin salas significant contantons con	thousing to death	Dut Hot resul	ung in un o un	derlying cause give	striir aiti.		Yes 2 □ No	3/☐ Proba	
7	COL W req	nous	Completed							24a. Was	s an 24b.	Were autor	osy findings available apletion of cause of
Ke	He la	certificate has rector, page 2	E O							auto perf	ormed? 🖊 📗	prior to con death? 1 \(\superset \text{Yes} \)	
~	Ita	is certificate na director, page	Be	25. Was case referred medical examiner?					26. Place of Dea			7	21
2:	OT V	<u>o</u> = 0	0	1 ☐ Yes 2 ②No		tient 2 E	R/Outpatient				idence 6 🗷 Otl		MOSPICE
7	VISION OF VITA Attending Physicien: r death.	funeral di	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D	ay Year)	Injury	28c. Injury Work	(? Yes 2 □ No	280. Describe	how injury occu-	rred	
e \ .	JIVISION OT VITAL MECONDS, or Attending Physicien: The law requires after death.	by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of la	njury - At hon etc. (Specify)	ne, farm, stre	et, factory, office			(Street and Num. wn, State)	ber or Rural	Route Number,
1/2	UIV	ied in											
E	UIVISIC the Hospitel or Attend hin 24 hours after death	o the runaral bractor: Atter the completely filled in by the funeral	edical	29a. Certifier 1	ician: To the bes er: On the basis and manner s	of examination	rledge, death on and/or inve	occurred at the timestigation, in my op	ne, date and place pinion, death occu	, and due to the irred at the time	cause(s) and m , date and place,	anner as sta and due to	ated. the cause(s)
	To the within 2	com	Ž	29b. Signature and title of certifier	1. 11			29c. License	number		29d. Date signe	ed (Month)	Day, Year)
	C	X		*/WWW/WM	/////			11/3	2012		113	1/1	5
	3	,		30. Name and address of person who co	mpleted cause of	death (Item	23a) (Type, F	and RN	/ B	1.46	UN!	110	10
		Stat	е	31. Date filed (Month, Pay, Year)	A2. Regis	trar's Signatu	1 W 00	111	20	714 ₁₎	161 ×	12/	U
	F	legistra	ır	AUG 0 2 2005	Elecine.	Irar's Signatu	BOOM						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** : Month 1550 M Sandra Lee Walters 31 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Upper Chesapeake Health Center Harford If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Jan. 10, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖺 F 216-52-4285 57 Yrs. Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Director Harford Edgewood 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 901 Swallow Crest Court Apt. D Items 23a 21040 Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2½ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 🗓 No White 3 → Widowed 4 □ Divorced Specify: "netural', 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) other then College (1-4or 5+) Elementary/Secondary (0-12) 11 Retail Management 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be fi and Mental F Is marked of Cletus Miller Dena Stoner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: if Item 27 Is rr any injury or other treum <u>once</u>. Tara Stickel Daughter 4018 Issacs Rd., Middle River, MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ■Burial 2 XCremation 3 □ Removal from State Bayview Crematory, Inc. 8-2-2005 4 Donation 5 Other (Specify) Baltimore, MD Signature of Funeral Service Lic 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** MOXIC encephaloudhy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dua to (or as a consequence or). Examiner The law requires that the death certificate be executed Cardiac arrest signed by the attending physician and be detached for use as the burial-trai resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, (ardiomy opathy 3 ☐ Probably 4 📆 Unknown 1 ☐ Yes 2 ☐ No infarction Acute GI breed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Furieral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 3∏ DOA 28a. Date of Injury (Month, Day Year) 27. Manne of Death 1 Natural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 3 🖺 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours aft To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier / 29c. License number 29d. Date signed (Month, Day, Year) 0-0063420 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zubair Siddia, M.D. 500 Upper Chesapeake Dr., Bel Air, MD
Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

SANDRA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#19a, perFH, C846, 8/2/05 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. N2 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 09:40 AM ul 200 30 /Medical ELNORA WATSON 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h. City Town or Location of Death Examiner anes Baltimi If Under 1 Year | If Under 24 Hrs. | ealthcare N/Aimore 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 ☐ M 2 💢 F Yrs. Director 243-70-2739 05/06/1942 NORTH CAROLIN Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show treumatic event, the Medical Exantrer roust be notified at Yes 2 No Director MD N/A BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23e 1020 N. ROSEDALE STREET 21216 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: þ Specify 3 Widowed 4 Divorced 'netural' BLACK Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed w h and Mentat Hygien 7 Is marked other th 12TH YEARS BILLING COORDINATOR HEALTH CARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be DAN WATSON GRACE PRINGLE ပ 19a. Informant's Name/Relatenship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 siment of Health an ent: If Item 27 Is ury or other treur MARY ANN WATON DAUGHTER 3510 PARKLAWN AVE, BALTIMORE, MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Magazial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: if any injury or once. TAVOR MEMORIAL 8/6/05 CERRO GERDO, NC 4 Donation 5 Other (Specify) PROBLES Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD En er the disease, or complications that caused the death heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Weel To not enter the mode of dying, such as cardiac or respiratory arrest, Immedia Cause (Final diseas or condition resulting in death) Spiratory Pnysician tailure /Medical Due to (or as a consequence of): **Examiner** umon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner Cause (Cisease or hijus that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes 2 No Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 0 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification; 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours af
To the Funerel D
completely filled i 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 caton Avenue, Abraham 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

AUG 0 2 2005

			1 - For State Registrar	State of Marylan	d / Depa		Health and I	Mental Hy	•		194
			1. Decedent's Name (First, Middle, Last))				2. Date of De	ath	3. Tim	e of Death
	Physici /Medio		Martin Thoma	as		Ward		July	$28^{\text{Day}} 200$	5 ^{ar} 11:	00 A M
1	Examir		4a. Facility Name (If not institution, give :	street and number)		4b. City, Town,	or Location of Death	h	4c. County of	Death	
			823 Buena Vista A	venue		Arnold			Anne	Arunde1	L
	Funeral		5. Social Security Number 6. Sex	3.1		If Under 1 Year Months Days		8. Date of Bir (Month, Da	th ty, Year)	9. Birthplace (Sta Country)	ite or Foreign
	Director		220-11-9333	XM 2□F 32	Yrs.			May 9,	1973	MD	
	and		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ecation				10d Inside	e City Limits
	vlanyl f •hc	5	MD Anne Arı								Yes 2☐No
	the 288-	Director	MD Anne Aru 10e. Street and Number	inder	AI	nold			10g. Citizen of Wh		X
	With Sa or	ā	823 Buena Vista A	Avenue			1012		U.S.		
	d within 72 hours after death with the Maryland liene. r then "netural", or items 23a or 28a-f ehow the Medical Examinar must be notified at	Funeral		12. Was Decedent Ever in U.	.S. 13. V		Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No		- American Indiar	٦,
9	after or ite	Ē	1 Never Married 2 Married	Armed Forces? 1 Yes 2 X No				o Rican, etc.)		White, etc.	
8	ral', c	l by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 🖔 No	Specify:		Specify:	white	
21215-0036	72 h	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a. Deced	dent's Usual Occu	pation	rkina	16b. Kind of Busi	iness/Industry	
21	within ene. then	фL	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of wor ad)				
2			17 Cabada Nasa (Cian Addul da a)	5+	Cable	Splice	Technic		Verizo		
ano	og ag bo ≥	Be	17. Father's Name (First, Middle, Last) William Ward						, Maiden Sumame)		
Ĕ	d Mer narke	2		0:-0	101 14 11		Martha				
Maryland	id 2 shouli Ith and Me 27 ie mark traumati	i	19a. Informant's Name/Relationship (Ty) Mr. William Ward /		4		t and Number or Ru				
di.	a E E		20a. Method of Disposition		_	sition (Name of	Drive, G	Date Durn	20c. Location - C		
Baltimore,	permit. Pages 1 Depertment of H Important: if ite eny injury or ot once.		1 Burial 2 □ Cremation 3 □R	lemoval from State	emetery, crer	natory or other pla	1				
틆	rtme rtani		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Jun ral Service License	Gle	n Have	n Mem. I	Park Aug	2,2005	Glen Bu	rnie, MD	
Ba	Deperment of the perment f the permet of		21. Signature of Johnan Sevice License	//.	2 1	. Name and Addr	ess of Facility S	ingleton	Funeral	Home P.	Α.
			23a. Part1. Enter the disease, or compli	15 MO/3/9			Avenue S			MD 210	
760, 🗞	Medical Examiner /Medical Examiner popularitansit	icai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence). Due to (or as a cons)	uence of):	Mila	Jon A.			Onset a	Between nd Death
P.O. Box 68	death certifice e ettending ph d for use as tl	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of do	death 3 = eath 5 =	Ectopic pregnanc Other (specify)			23d. Date of Month		Year
	6 00	٤	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the ur	nderlying cause gr	ven in Part I.	23e. Did to	obacco use contrib Yes 2 No 3	ute to the cause	
ပွဲ	w require been si should t	ete					· · · · · · · · · · · · · · · · · · ·		/,		
Vital Records,	The law cete hes I	Completed							osy prio rmed? dea	ore autopsy finding or to completion of ath? ☐ Yes 2☐ No	of cause of
<u>ra</u>		BeC	25. Was case referred to medical				26. Place of Dea	th (Check only o		1165 20 140	
\geq	S S D	ToB	examiner? 1 ☐ Yes 2 X No	lospital:	ER/Outpatien	t 3 DOA Ot	her	- N- 1 - 3010	dence 6 Other	(Specify)	
0			27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju			now injury occurred		
<u>ō</u>	Attending r death. sctor: After by the fune	atic	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Moral, Say Your)	mjary		Yes 2 □No				
Division of	P # 2 =	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre	eet, factory, office		28f. Location (S City or Tox	Street and Number vn, State)	or Rural Route N	lumber,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: campletely filled in by the	edical	29a. Certifier 1 Cartifying Physical (Check only one) 1 Medical Examin	sician: To the best of my knot ner: On the basis of examinal and manner stated.	wledge death tion and/or inv	occurred at the ti restigation, in my	ime, date and place opinion, death occur	and due to the rred at the time,	causs(s) and nann date and place, and	er at etated. d due to the caus	60(s)
	To t	Σ	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed (Month, Day, Year	r)
			101	<i>پر</i> ح.		319	6520		7/29	105	
	σ .		30. Name and address of person who op	mpleted cause of death (Item	23a) (Type,	Print)			LII.		
_	\		Johniter	ישנה שני	107	153 FA	LLS NJ	1. hor	the allo	53 Z	1053
.t.	Sta Registr		31. Date filed (Month, Day, Year) ALIG 0.2 2005	32 Registrar's Signal	ture	A.					

DHMH 17 Rev 1/2001

		rie						colth and A	=		_	
-		For State Registrar	State	or Iviar		ertifica		ealth and N Death	nentai my	_	005	25195
2 Physici		1. Decedent's Name (First, Mide Dan Yanis	dle, Last)						2. Date of D Month July		005 Year	3. Time of Death 3:00 p M
/Medie		4a. Facility Name (If not instituti		ımber)		4b. City	, Town, or	Location of Death			County of Deal	-
0		Gilcrest Hospi	ce			Tows	on				.1timore	
Funeral Director		5. Social Security Number 549-43-2827	6. Sex 1 ☑ M 2 ☐ F	7. Age (50	In yrs. last birthd Yrs	Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D 09-16-	inth 1954	9. Birt	hplace (State or Foreign buntry) inois
SO		Usual Residence of Decedent			Oc. City, Town o							Las interior in the
Ly 27, 2005 Fr death with the Maryland tems 23a or 28a-1 show	o	MD 10b. Coun	У		Baltimo							10d. Inside City Limits
h the I	Director	10e. Street and Number				10f. Z	ip Code			10g. Citi	zen ol What Co	puntry?
Lith with with with with with with with w	aiD	416 Kane Stree	t			21	224			U.S.	Α.	
to me	nuel	11. Marital Status	12. Was Dec Armed F	cedent Ev orces?	er in U.S.	3. Was Dece II Yes, spi	edent of Hi	spanic Origin? (Sp n, Mexican, Puert	pecify Yes or N Rican, etc.)	0-	14. Race - Ame Black, Whit	
036 ours after	by Funeral	1 🛱 Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	arried 1 ⊡Yes IIYes, G ed Year or I	2⊠No ive Dates:		1 ☐ Yes	2 ₺ No	Specify:			Specify:Rom	anian
Maryland 21215-0036 As should be filed within 72 hours after death with the Marylan th and Mental Hygiene. The marked other than "natural", or itema 23a or 28a-1 show traumatic event, the Medical Exp. Life from the motified at	Completed	(Specify only high	ent's Education est grade completed		(G	cedent's Usi live kind of w e. DO NOT	ual Occupa ork done d use retired,	ition luring most of work)	king	16b. Ki	nd of Business/	Industry
212 212 d with giene.	mo	Elementary/Secondary (0-12)	College	(1-4or 5+)		tructi	on Wo	rker		Con	structi	on
nd be file tal Hy d oth	Be	17. Father's Name (First, Middle	a, Last)					18. Mother's Nam		e, Maiden	Sumame)	
Maryla Varyla 12 should I h and Meni 7 is merke	၉	Steve Demitro						Dorothy				
Mar Mar d 2 sh th and th and traum traum		19a. Informant's Name/Relation Helen Lee/ Com				-		ind Number or Ru t Baltim				Zip Code)
re, M s 1 and 2 f Health tiom 27 l		20a. Method of Disposition							Date PID		cation - City or	Town, State
Pages nent of internal internal of internal of internal i		12□XBurial 2 □ Cremation 4 □ Øpnation 5 □ Other		State	20b. Place of Di cemetery, E1mwood	Cemet	ery	" 08 -	02-05	Riv	er Grov	e, I1
Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: if item 27 is marked other than angulary or other traumatic event, the Mance.		21. Si ma ure of Funeral/Service	e Licevis de	oher	X	22. Name a Ambro 1328	nd Addres se Fu Su1ph	s of Facility neral Ho ur Sprin	me of I	ansd ansd	owne owne MD	21227
Wedical Examiner of the purial-transit in burial-transit in burial	licai Examiner	23a. Part 1. Enter the disease shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	(or as a coordinate of the coo		rtic.		y Cutric		arrest,		Approximate Interval Between Onset and Death
Records, P.O. Box 687. The law requires that the death certificate the has been signed by the attending physiones 2 should be detached for use as the late.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		birth 2 nant at tir	pregnancy Fetal death me of death	3 □Ectopic p 5 □ Other (s					23d. Date of dei Month	ivery Day Year
ds, P uires that signed b	Ď	Part II. Other significant condi	tions contributing to	death but	not resulting in th	e underlying	cause give	en in Part I.				o the cause of death?
Cord w requir	iete								24a. Wa	s an	24b. Were au	utopsy findings available completion of cause of
I Re The la	Completed								auto peri 1 ☐ Yes	opsy formed? 2 12 No	death?	completion of cause of 2□ No
/ita cian: ertifici ector,	Be	25. Was case relerred to medic examiner?						26. Place of Dea	th (Check only			11
n of \ ing Physi After this o	lon: To	1 ☐ Yes 2 No 27. Manner of Death 1 ☐ Natural 5 ☐ Pend	28a. Date (Mo.	Inpatient of Injury oth, Day		e ol	28c. Injury Work	at	ome 5 Res 28d. Describe		Other (Spe y occurred	city torpice
Division of Vital Records, To the Hospitel or Attending Physician: The law requires the within 24 hours effer deeth. To the Funerel Director: Affer this certificate has been signe completely filled in by the funeral director, page 2 should be	Certification:	3 ☐ Suicide 6 ☐ Coul	minor 286, Plac	e of Injury ding, etc.	y - At home, larm (Specify)	, street, facto		/es 2 □ No	281. Location City or To	(Street an own, State	d Number or Ru)	ural Route Number,
Hospitel 24 hours (Funerel stely filled	Medical Co		ring Physician: To the all Examiner: On the and ma									
Fo the vithin Fo the comple	Me	29b. Signature and title of certification	ier /	<i>I</i> */		29	9c. License	number		29d. Dat	e signed (Mont	h. Dey, Year)
		> 9/ Ant	hong the	ly,	un)		02	5205		Ju	Ly 27,	2005
3		30. Name and address of person	n who completed cau	ise of dea	th (Item 23a) (Ty	Pe, Print)	-l	- St, &	culto.	md	2120	×
Sta Regist	ate rar	31. Date filed (Month, Day, Yea AUG 0	ier and ma	Registrar	s Signature	parte			5			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear Physician Month 649 AM Zur 30 110 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** None 24 Hrs 8. Date of Birth (Month, Day, Year) Sept 13, 1934 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1**X**1M 2□ F Hours 076 26 6591 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow the Medical Examiner must be notified at 1 ☐ Yes 2 No **Funeral Director** MD Ellicott City Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a or 21042 United States 12430 Triadelphia Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours atter near to Health and Mental Hygiene. nnt: If item 27 is marked other than "natural; or file nny or other traumatic event, the Medical Expriment Affiled Folkes. 1∑Yes 2 □ No If Yes, Give Year or Dates: unk. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry National Elementary/Secondary (0-12) Coilege (1-4or 5+) Security Agency Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Trene Waldele Charles Zura 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12430 Triadelphia Road Ellicott City, MD 21042 Judith P. Zura/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Daurial 2 Cremation 3 Removal from State Department of Important: If any injury or Crest Lawn Mem. Gard. 8-3-2005 Marriottsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 24 hour . Ischemic Bowe disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner obstruction omplete small bowel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Completed by Physician/Medical Examiner Abdominal Aprtic Aneur Sm Hospital or Attending Phyalcian: The law requires that the death certificate be executed AAA HUP-UTED burial-tran that initiated events resulting in death) Last Due to (or as a consequence of P.O. Box 68760. use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2X No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 □ No page 2 autopsy performed? 1 Yes 2□ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide within 24 hours a To the Funeral [29a. Certifier 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 1/2001

State Registrar WOLFE ST

RES-000

BALTIMORE MO 21287

July 30, 2005

Mast

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MID

600 N.

Registrar's Signature -

L MATZEN

AUG 0 2 2005

SUSCERNA

31. Date filed (Month, Day, Year)

		For	State of M	aryland.	-				and Me	ental Hyg	iene			
		1 - State Registrar			Cei	rtificat	e of L	Death			eg. NO	005	2519)7
Physicia	an	Decedent's Name (First, Middle, Last	Julia <i>A</i>	nn 701	nn					2. Date of Deat Month	Day	Year	3:50 p.	M
/Medic		4a. Facility Name (If not institution, give			pp	4b. City,	Town, or	Location of	of Death	July	/ 29, 2 4c. 0	2005 County of Death	· ·	
Examin	ier	,	811 Hilltop R			,			Caton	sville		Balti	imore	
Funeral		5. Social Security Number 6. S	ex 7. Ag	je (In yrs. last		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birth	place (State or i	Foreign
Director		234-78-5183	□M 20 F	57	Yrs.		J., C			March 12,			Arizona	
wo man		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation							10d. Inside City	Limits
Mary sh	ţ	Maryland Balt	timore				Ca	tonsvill	e				1 ☐ Yes 2	2 X NO
th the or 28e	Director	10e. Street and Number				10f. Zip				1	0g. Citize	en of What Cou	ntry?	
13-0030 172 hours after death with the Maryler "neturel", or itame 23e or 28e-1 show raical Fracili or trast be notified at	rai	811 Hilltop Rd						212				U.S.		
er dez itame	Funerai	11. Marital Status	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🛣	Ever in U.S.	13.	Was Dece If Yes, spe	dent of Hi cify Cuba	spanic Ori n, Mexicar	gin? (Spec s, Puerto R	cify Yes or No- lican, etc.)	14	 Race - Ameri Black, White, 		
or, or	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	140		1 🗌 Yes	2 X No	Specify:			9	Specify:	White	
2 hot	ted	15. Decedent's Ed	ducation	1	6a. Dece	dent's Usu	ai Occupa	ation during mos	t of workin	2	16b. Kind	d of Business/Ir	ndustry	
ithin 7	Completed	(Specify only highest gra	College (1-4or	5+)	life.	DO NOT u	se retired,)	OF WORKIT			Finar	ncial	
be filed within 72 hours after death with the Marylend be filed within 72 hours after death with the Marylend delbygiene. delbygiene.		12. Father's Name (First, Middle, Last)					A	uditor	r's Name	(First, Middle, I	Maiden 9	Sumame)		
d be find he of the ded of	Be c		Mangelo					TO. INIOTHE	3 1441110		len Bo			
ar yra	2	19a. Informant's Name/Relationship (19b. Mailir	ng Address	(Street a	and Numbe	er or Rural			Town, State, Zij	code)	
and 2 and 2 ealth a n 27 is		Mr. Brian Bucklew	Fiance	ee _	8	11 Hillto	p Rd	Catons	ville, M	aryland 21	228			
D - 1 5 5		20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐	Removal from State	anm.	e of Dispo etery, crei	sition (Name	ne of other place	e)	71.2	ate	20c. Loc	ation - City or T	own, State	
Pages tment of I tent: if its		`4 ☐ Donation 5 ☐ Other (Specify	y)					ices, In		05 _	5	Sykesville,	Maryland	
Date.		21. Signature of Funeral Service Licer	1500	110129	3 22			ss of Facilit uneral !	257 - 67	Δ				
40240		23a. Part1. Ent I the diseas , I r com	Lications that cause	UILT	On not ent	3	871 OI	d Colur	nbia Pi	ke Ellicott		MD 21043	Approximate	
		shock, or heart failure. Ut only	one cause on each li	ine.	1	or the the				roophatory arr	001,		Interval Betwee	∋en ∋ath
Physician /Medical		disease or condition resulting in death)	a	a consequen	Los of).	25		-anc	21					
Examiner			b 00 to (01 d 0	a concequen	00 017.									
n s	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying	Due to (or as	a consequen	ce of):									
ecuter and -trans	Examiner	that initiated events resulting in death) Last	C. Due to (or se	a consequen	oo of\:									
of ou, sate be executed bhysician and the burial-transit	ai E	,	Due to (or as	a consequen	01).									
The Coldus, F.C. Box 80100, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edicai		_ d								-			
w requires that the death certific been signed by the attending p should be detached for use as	hysician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy		Ectopic p	regnancy				23	3d. Date of deliv		
deat beatth	sicis	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant a			Other (sp						Month	Day Ye	ar
d by the	Phy	9 ☐ Unknown Part II. Other significant conditions of	contributing to death t	out not reculting	on in the u	adarhijas s	Pause alve	an in Part I		23e Did tol	Dacco us	e contribute to t	he cause of dea	ath?
ries the signer of the d	by	Part II. Other significant conditions of	onthouring to death t	out not resulti	ig iii iil o u	riderlying t	ause give	ati ini Fanti	•	12 Y			bably 4 ∐Un	
law requires as been signed as been signed as been signed as a should be a signed as a sig	ompieted									24a. Was a	1	24h Were auto	opsy findings av	vailable
he lav	dmo									autops	ned?_	prior to co death?	ompletion of cau	ise of
	e Co	25. Was case referred to medical						26 Place	of Death	(Check only on	2 No	1 🗆 Yes	2 L No	
Physicien: Physicien: r this certific ral director,	0	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpati	ent 2□ER	/Outpatier	nt 3 🗆 D0	Othe Othe					□Other (Special	fy)	
ng Phy riter this	n: T	27. Manner of Death Natural 5 Pending	28a. Date of Inju	ary 28	b. Time o	f :	28c. Injury Work	/ at		8d. Describe ho				
sion tendir eath. or: Al	catio	2 Accident investigation 3 Suicide 6 Could not b				М		Yes 2 🗆						
Olvision or Attending after death. Director: Afte	ertification:	4 Homicide determined		jury - At home tc. <i>(Specify)</i>	, farm, sti	eet, factor	y, office		2	City or Town		Number or Run	al Houte Numbe	91,
spitei ours a nerei I	O	29a. Certifier Certifying Ph	nysician: To the best	of my knowle	edge, deat	h occurred	at the tim	ne, date an	d place, a	nd due to the ca	ause(s) a	and manner as s	stated.	
To the Hospitel or Attending Physwithin 24 hours atter death. To the Funerel Director: After this completely filled in by the funeral director.	edical		niner: On the basis of and manner st	of examination										
To th withir To th	M	29b. Signature and title of certifier				29	c. License			2	-	signed (Month,		
10		1 vite () wo					108:			5	1/2 30	120	05
14		30. Name and address of person who	pleted cause of c	death (Item 23	Sa) (Type,	Print)	PI.	ace	0	bultimo	re,	WD	2120	3
Sta Registr		31. Date filed (Month, Day, Year) AUG 0 2	pleted cause of cause	rar's Signature	ß,	Sport	w w							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2 1 1 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** August 2, 11:07 p M 2005 **Gladys** F. Bailey /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Reisterstown 318 Wembley Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. July 12, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🖾 F 1939 Maryland Director 219-34-7052 66 Usual Residence of Deceden with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10h County 10a State Itams 23e or 28a-f show 1 Yes 2 No MD Reisterstown Baltimore Directo 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 21136 U.S.A. 318 Wembley Road death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☎ No If Yes, Give Year or Dates: Race - American Indian, Bleck, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. han "natural", or ita Medical Examina 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 20 Clerk Dept Store 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph Baker Gladys Loving 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Paul F. Bailey 318 Wembley Road Reisterstown, Maryland 21136 Husband Importment of He Important: If item any injury or other once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 8/6/05 Lake View Mem Park Sykesville, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 11824 Reisterstown Road 21. Si patr e of Funeral Sepice Licens Reisterstown, Maryland 21136 Eline Funeral Home tin 231. Part1. Enter the disease, or complications that caused the deathy shock, or heart failure. List only one cause on statement of the cause of the of not enter the mode of gring, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final IN Physician di ease or condition resulting in death) /Medical Due to for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknow signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant condition intributing to death but not resulting in the underlying cause given in Part I. ð 12 Yes 2 □ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has e 2 1 ☐ Yes 2 ☐ No 2 2 No certificate 1 Yes Hospitel or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 5 Residence 6 Other (Specify) Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 No 3 DOA 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Diractor: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Thomicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Implicate Examiner: On the basis of examination and/or investigation in my spiritual death. 29a. Certifie Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature 0 D00549 Ano completed cause of death (Item 23a) (Type, Print) BAHMORE MD 21215 30. Name and vedent Ave. ich 31. Date filed (Month, Day 32. Registrar's Signature Year State Registrar

DHMH 17 Rev 1/2001

		1. Decedent's Name (First, Middle, Last)				Date of Death Month D	ay Year	Time of Death
Physicia /Medic	_	A	ELEN JEAN BER	CHHEISEL		JULY 28.	•	8:03 A M
Examin		4a. Facility Name (If not institution, give s EASTON MEMORIAL I	street and number)	4b. City, Town, or Loc EASTON	cation of Death		c. County of Death TALBOT CO)
Funeral Director		180-26-0387	7. Age (In yrs. last birthday,		lours Min.	Date of Birth Month, Day, Yea KUARY 18,	Cou	place (State or Foreign ntry) (SYLVANIA
show	ō	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits 1 □Yes 2 No
ours after death with the Maryland	Director	10e. Street and Number	PALLE	10f. Zip Code	1658	10g. C	Citizen of What Cou	ntry?
death rms 2:	Funeral	10 & LONG V	12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispa If Yes, specify Cuban, N	nic Origin? (Specify	Yes or No-	14. Race - Ameri Black, White	
ours after rei', or ite Examine	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?/ 1 Yes 2 PNo If Yes, Give Year or Dates:		ресіту:		Specify: W//	11/E
"naturel",	letec	15. Decedent's Edu (Specify only highest grade	completed) (Give	dent's Usual Occupation kind of work done during DO NOT use retired)	n ng most of working	16b.	Kind of Business/Ir	ndustry
filed withir Hygiene. other than ent, the M	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	URSE		1	1EOICAL	
e d la b €	To Be C	17. Father's Name (First, Middle, Last) To HN W. HA	BB ERSHOH	18.	Mother's Name (Fin	st, Middle, Maide	en Sumame)	
2 should and Mer is marke aumatic		19a. Informant's Name/Relationship (Ty		ing Address (Street and	Number or Rural Ro	ute Number, City	or Town, State, Zi	o Code)
permit. Pages 1 and 2 should Department of Health and Mer Important: if Item 27 is marke eny injury or other traumatic ance.	1	ERNO BERNHEIS (20a. Method of Disposition	EL / HUS BAND 10 20 20b. Place of Disp	osition (Name of	QUE FNS	oury 14	Location - City or T	own, State
ages int of h t; if ite	П	1 ☐ Burial 2 ☑ Cremation 3 ☐ R	emoval from State	matory or other place)	8/2/1	Ba	Timore	1001/1010
permit. Pages Department of Important: if if eny injury or c		4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	BAYVIEW 2	2. Name and Address of	Facility MARZ	VILLA FO	HERAL CH	APEL PA.
permit. Depart Import eny inj once.		muchael I m	argullo a	6009 HARFOR	ED ROAD	_		LAKD 21214
Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the death. Do not enter a cause on each line. Traxodone Intoxica		uch as cardiac or res	spiratory arrest,		Approximate Interval Between Onset and Death
_/Medical Examiner	İ	resulting in death)	Due to (or as a consequence of):					
	liner	Sequentially list conditions, large sample immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):					
te be executed ysician and ne burial-transit	cal Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):					
0 %								
Attending Physician: The law requires that the death certificate to death. r death. sctor: Atter this certificate has been signed by the atlending physic the funeral director, page 2 should be detached for use as the to	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)			23d. Date of deliving Month	ery Day Year
that the ed by the detach	Phy		ntributing to death but not resulting in the	underlying cause given in	n Part I.	23e. Did tobacco	use contribute to	the cause of death?
w requires that the death been signed by the atte should be detached for	ted by					1 🗆 Yes	2□No 3□Pro	bably 4 Unknown
The law r te has be bage 2 sh	Completed					24a. Was an autopsy performed? Yes 2□	prior to co	opsy findings available ompletion of cause of
sian: artifica ctor, p	Bec	25. Was case referred to medical examiner?			3. Place of Death (Cl	/\		
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ဥ	1 X Yes 2 No 27. Manner of Death 1 Natural 5 Pending	1 Inpatient 2 Pr/Outpatie 28a. Date of Injury 28b. Time of Injury Injury	of unk 28c. Injury at Work?	4 Nursing Home 28d.	5 Residence Describe how in		fy)
r Attendi ter death. irector: A irector: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	7-28-05 28e. Place of Injury - At home, farm, sibuilding, etc. (Specify)		28f.	Location (Street City or Town, Sta	gested dr and Number of Rui 102 Lon	
lospital o	cal Ce	29a. Certifier 1 Certifying Phy (Check only 217 Medical Exami	Home sician: To the best of my knowledge, dea ner: On the basis of examination and/or in	th occurred at the time, on the stigation, in my opinion	Que	enstown	(s) and manner as	stated
the hin 2, the find 2, the find find find find find find find find	Medical	29b. Signature and title of certifier	and manner stated.	29c. License nu			Date signed (Month	
₹ ¥ £ 8		1 Sauton	Lemo	O C M			LY 29, 20	
		0 0						

	_ FUI	partment of Health and Mental I	
	1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg. N2 0 0 5 2 5 2 0 0
Physicia	SYLVIA HUDERT BROOKS	Month	Day Year 10 25 Q
/Medica	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
CAMITIE	Sinai Hoppital of Baltimore	Balhmore City	N/A
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. (Month)	Birth Day, Year) 23,1940 9. Birthplace (State or Foreign Country) Mary I and
Director	214-38-4330 1 M XXX 64 Yrs. Usual Residence of Decedent	August	23,1940 Maryland
anyland show	10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits
Mary P-f sh	Maryland Baltimore Timonia	ım	1 □Yes 2 □No
vith the Maryla or 28a-f shou	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
23a ust b	14 Tullycross Ct	21093	USA
er dea lteme		 Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc. 	r No- 14. Race - American Indian, Black, White, etc.
036 bours after death v rat', or iteme 23e Examinar must.	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 27 ☐ Mb 3 ☐ Widowed XX Zivorced Yes, Give Year or Dates:	1 ☐ Yes X (X) No Specify:	Specify: White
21215-0036 ed within 72 hours after death with the Maryland ygiene. ser than "natural, or iteme 23s or 28s-f show it, the Madical Examinar must be notified at		cedent's Usual Occupation ve kind of work done during most of working	16b. Kind of Business/Industry
21215-0 21215-0 3 within 72 ho jiene. rithen "natuu	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	
V 7 5 5 5	Z 17. Father's Name (First, Middle, Last)	Administrative Assista	
Irylahd should be fill marked out	George Joseph Hudert	Elizabeth	
aryia 2 should I	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street and Number or Rural Route Nu	
S Pala		ld Cherry Court Reisters	town, Maryland 21136
Imore,	YM Burial 2 Cremation 3 Deemoval from State	position (Name of Pate Place)	20c. Location - City or Town, State
timent tant:	1 d □ Donation 5 □ Other (Specify) Dulaney Vo	alley Mem Gar 8/1/05	Timonium, Maryland
Baltimol permit. Pages Department of important: If I any Injury or o	Signature of Funeral Service Licensee Charles Charles		Wiedefeld Funeral Home Inc Baltimore, Maryland 21212
	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or respirato	ry arrest, Approximate Interval Between Onset and Death
Pnysician	Immediate Cause (Final disease or condition resulting in death)		Onset and Death
/Medical Examiner	Due to (or as a consequence of):		
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
executed in and in-transit	that initiated events C.		
760, be executed siclan and burial-transit	resulting in death) Last Due to (or as a consequence of):		
8760 cate be e	d		
S, P.O. Box 6i	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
Boath death death death	1 Vac 2 Mala 4 Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)	Month Day Year
P.O. that the do by the detached	9 □ Unknown		
Division of Vital Records, P.O. Box 6 to attending Physician: The law requires that the death certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as	Part II. Dther significant conditions contributing to death but not resulting in the		Did tobacco use contribute to the cause of death?
Il Record The law require cate has been sir			
Rec ne law has t		a	Vas an utopsy erformed? 24b. Were autopsy findings available prior to completion of cause of death?
Vital Re	25. Was case referred to medical	1 ☐ Ye 26. Place of Death (Check or	
of Vita hysician his certifi	examiner? 1 Yes 2 Hospital: 1 Matient 2 ER/Outpat	Other	Residence 6 Other (Specify)
on of Vita iing Physician: After this certific funeral director.	27. Manner of Death 1 ☐ Matural 5 ☐ Pending (Month, Day Year) 28b. Time Injury	of 28c. Injury at 28d. Descri	be how injury occurred
isior wtendin death. ctor: Af	2 Accident investigation	M 1 Yes 2 No	
Division C tat or Attending P s after death. al Director: After t ed in by the funers	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		n (Street and Number or Rural Route Number, Town, State)
spital	29a. Certifier 1 Dertifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place, and due to	the cause(s) and manner as stated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transli	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred at the tir	ne, date and place, and due to the cause(s)
To the within To the complex c	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
*	munitary 1 100	7,0013	July 24, 200
10	30. Name and address of person who completed cause of death (Item 23a) (Typ Aunew (7. / Earl VES Mm 240 M	1. BELVEDENE AVENUE,	BANTMORE, MD 21228
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature		
Registra	AUG 0 3 2005 Regue &	parte	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July ^{Day} 2005 **Physician** 30 9:30pM Carolyn Ε. Brown /Medical 4a. Facifity Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner / Ruxton Towson Baltimore Manor Care ff Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 🔀 F Yrs. 71 16,1934 NorthCarolina Director 238-42-7026 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if item 27 is marked other then "neturel", or items 23a or 28s-f show any injury or other traumatic event, the Macalical Exstricts must be notified at once. 10c. City, Town or Location 10d. fnside City Limits 10a. State 10b. County 1 ☐ Yes 2€ No Director MD Baltimore Middle River 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12529 Gracewood Drive 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐ No ff Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Colfege (1-4or 5+) Homemaker own home 10th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Price Leona Conder 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carol Brown 17 Milton Ave. Fallston MD 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 8/2/05 Baltimore MD BayviewCrematory 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee 300 MAce Ave. Baltimore MD 21221 118 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Op not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only she cause on each line. fmmediate Cause (Finaf a **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be axecuted the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent preceant in the past 12 menths?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2 10 3 Probably 4 Unknown 1 Tes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? res 2 No certificate the Hospital or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director: filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier use of death (Item 23a) (Type, Print) 30. Name and address of person who comp ted o 6701 1 M AHA MO gistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

AUG 03

2005

			. For		nt in Black in laryland / Depa	artment of H	ealth and M	-	_	
			- State Registrar		Cei	rtificate of l	Death		eg. No. 200	5 25202
22.	Physici		Decedent's Name (First, Middle, L.	~ .				2. Date of Dear Month	Day Year	
	/Medic		beenadette	F Behre				AUGUST	2 200 4c. County of De	-
	Examin	3	4a. Facility Name (If not institution, gi	of Boult	imore	Baltiv			Bolt	more
	Funeral * Director		c77 18 6874	Sex 1 □ M 2 🔀 F	ge (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day	Year)	irthplace (State or Foreign Country)
	death with the Maryland bms 23a or 28s-f ehow if mout be rediffed at	tor	Usual Residence of Decedent 10a. State 10b. County MD Car	roll	10c. City, Town or Lo	ocation oodbine				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the	I Direc	10e. Street and Number 935 Hoods Mill R	oad		10f. Zip Code 217	97	1	0g. Citizen of What 0	Country?
36	s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23a or 28a-f ehow then traumatic event, the Medical Examinar must be riverliked.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Vivorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	(No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify: W	
21215-0036	within 72 hou ene. than "natura ne Medical E	Completed	15. Decedent's (Specify only highest g		(Give	dent's Usual Occup kind of work done of DO NOT use retired al Health	during most of work f)		16b. Kind of Busines Health	ŕ
	id be filed withi ental Hygiene. ked other than ic event, It a M	To Be Co	17. Father's Name (First, Middle, La: Bernard	McLaughli			18. Mother's Nam		Maiden Sumame) ftus	
Maryland	nd 2 should be lith and Mental 27 is marked r traumatic ev	-	19a. Informant's Name/Relationship Mr. Thomas Behre						r, City or Town, State	, Zip Code)
Baltimore,	Pages 1 and 2 ent of Health nt: If Item 27 I ry or other tre		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec			osition (Name of matory or other place ty Cremat	ce)		20c. Location - City ϵ Sykesvi 11ϵ	
Balti	permit. Pages Department of It Important: If ite any injury or of		21. Signature of uneral Service Lice	-	H H	Algaid fun ykesville	ERAT HOME	E & CHAP 34 (410)	EL, PA (Bo -795-1400	ox 195)
Å	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Due to (or a	ed the death. Do not en line. ORONARY is a consequence of):				est,	Approximate Interval Between Onset and Death 20 YEARS
68760, %	icate be executed physicien and s the burial-transit	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or a	is a consequence of):					
.O. Box 68	death certif e attending id for use as	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 Fetal death 3 at time of death 5	□Ectopic pregnanc □ Other (specify) _	1		23d. Date of o Month	delivery Day Year
Δ.	signed d be del	ρ	Part II. Other significant condition: PERIPHERAL	VASCULAR	DISEASE			23e. Did to	/	to the cause of death? Probably 4 Unknown
Division of Vital Records,	e taw hes b	Completed	PAROXYSMAL				ASE	24a. Was autop perfor	sy prior t med? death	autopsy findings available to completion of cause of ess 2 10 No
tal	ician: Th certificate rector, peç	0	25. Was case referred to medical	FILITING	T (I) T (I)	10.0	26. Place of Dea			
\geq	d is	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Linpa	tient 2 ER/Outpatie	ent 3 DOA	ner: 4 Nursing H	ome 5 Resid	lence 6 Other (S	pecify)
ion o	ne (fee		27. Manner of Death 1 Natural 5 Pending 2 Accident investiga		njury 28b. Time Day Year) Injury	Wo	ry at rk?]Yes 2 □ No	28d. Describe h	low injury occurred	
Divis	F 8 F 5	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	200. Flace UI	Injury - At home, farm, s etc. <i>(Specify)</i>	treet, factory, office		28f. Location (5 City or Ton	Street and Number or m, State)	Rural Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical ((Check only 2 Medical Ex	Physician: To the be aminer: On the basis and manner	st of my knowledge, dea of examination and/or i stated.	nvestigation, in my	opinion, death occu	rred at the time,	date and place, and d	due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	0.1	C 07 -	29c. Licens			29d. Date signed (Mo	
7	. /		> Peter U	1. Cho	SURGEON	D4	1129		AUGUST 2 N. Belved	, 2005
_	4		30. Name and address of person w		i death (Item 23a) (Type		16'unne	24011	N. Belveck	eve Ave.

State Registrar 31. Date filed (Month, Day, Year)
AUG U 3 ZUU3

32. Registrar's Signature

BEHRENS, BERNADETTE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. N. 2005 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12:05PM BIVENS 2005 MON 4c. County of Death 4b. City, Town, or Location of Death Name (If not institution, give street and number Ivania A 1100 tennsu 8. Date of Birth (Month, Day, Year) JAN 5, 19 if Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) Days Hours 1 M 2□F Months 215-28-2526 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County MD 1 Yes 2 □ No Himore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ISA 21202 1100 tennsulvania 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent 11. Marital Status Armed Forces? 1 AYes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working [ing. DO NO] use regired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ondary (0-12) College (1-4or 5+) ustodiar (First, Middle, Last) 20b. Place of Disposition (Name of cemetery, crematory or enter) Method of Disposition 1 Burial 2 Gremation 4 Donation 5 Other (Specify) Burial 2 ☐ Cremation 3 ☐ Removal from State 21. Signatur of Funeral Service Licensee allstown, NO 2/133 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such is cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CEREBRAL THROMBOSI disease or condition resulting in death) ARTERIOSCLEROTIC CEREBROVASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) DIABETES that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. VASCULAR RTENSIVE 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? PERLIPIDEMIA 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 🗌 Yes 25. Was case referred to medical examiner? 1 \(\sum \text{Yes} \) 2 \(\sum \text{No} \) 26. Place of Death (Check only one) Other: 4 Nursing Home Mesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 2 Accident 5 Pending 1 🗆 Yes 2 No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

/Medical Examiner Examiner attending physician and for use as the burial-transit Box 68760, Physician/Medical the use as I Records, P.O. þ Completed completely filled in by the funeral director, Be 2 Certification: After

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

r than "natural", or Itams 23a or 28a-f shov the Medical Examinar must be mutified at

othar

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any linjury or other traumatic event ODGS.

Physician

Completed by Funeral Director

Be ဂ္

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Division of Vital To the Hospital or Attending I within 24 hours after death. To the Funaral Director: After

State Registrar

Medical

29a, Certifier

30. Name and address of person who complete 31. Date filed (Mont)

29b. Signature and title of certifier

of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

ATIENT BETTY

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 1230 AN 07 30 2005 Mary Chesgreen /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Elkridge,
If Under 1 Year | If Under 24 Hrs.
Months Days | Hours | Min. Howard 6616 Pheasant Drive Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 27 F 84 JUNE 11, 220-03-8779 1921 Maryland **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County or then "natural", or Itama 23e or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director MD Howard Elkridge 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6616 Pheasant Drive 21075 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or Itama 23a any Injury or other traumatic evant. The Medical Examiner musts once. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (Unavailable) Frank Ryan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6616 Pheasant Drive, Elkridge, MD Dennis Chesqreen - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/2/2005 Meadowridge Mem. Park Elkridge, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, MD 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ZYEARS DISEASE **Physician** ALZHEIMER'S disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the deeth certificate be executed burial-transit that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 4 Pregnant at time of death 5 Other (specify) the a 9 Unknown is signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION OSTEO ARTHRITIS OF KNEES Completed 24b. Were autopsy findings available prior to completion of cause of death? HYPERLIPIDEMIA 24a. Was an autopsy SYNDROME 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending 1 Yes 2 No hours after death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 D 22832 08/02/2005 mu Can 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5808 MAIN STREET ELKRIDGE M. D 32. Registrar's Signature 31. Date filed (Month, Day, Year) AUG () 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. N2 U 0 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** JOHN CHITTENDEN 2:35 AM FLEMING 31 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Union Memorial Hospital Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) Year) | October 16, 1921 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 83 XX M 2□ F Iowa 212-20-8316 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ir than "natural", or Itams 23a or 28e-f show the Medical Examiner must be notified at XXYes 2 □ No Directo Baltimore Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21210 4402 Roland Springs Dr USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XXes 2 □ No WWII If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 Ia marked othar than "natural", or Ita 1 Never Married 2 Married 1 ☐ Yes 2 XX No Specify: White Baltimore, Maryland 21215-0036 Specify by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Ship Repairman Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Fleming Henry Ward Chittenden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4402 Roland Springs Dr. Baltimore, Maryland 21210 19a. Informant's Name/Relationship (Type, Print) Wife Frances Boone Chittenden 20a. Method of Disposition
1 □ Şurial XX Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o GreenMount Cemetery 8/5/05 Baltimore, Maryland 4 Donation 5 Other (Specify) ice Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypoxia **Physician** 1 Day /Medical Due to (or as a consequence of): **Examiner** Bilateral 1 Day PREUMORIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed 1 Day 560818 ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown DILEUSE Be Completed Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an certificate has autopsy performe 1 ☐ Yes 2 12 No or Attanding Physiclan: . After this certifical funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Department 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 21 No Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Wasser 31 2005 Hassan D0053617 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21218 201 East University Pankway Nasser Hassan 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0.3 2005 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#17, perFh. C846, 8/3/05 TI State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. NO 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** CANTY 2005 OMIE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE CENTER MERCY MEDICAL N/A If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 10M 20F 78-6267 Days 9 02 1946 S. Carolina Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at XXYes 2 ☐ No BALTIMORE MD Director BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21218 SA ANVALE ST 2210 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ₹ \$\frac{1}{2}\$ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1□ Yes 2□ No Baltimore, Maryland 21215-0036 Specify Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) & O Railroad Laborer 8th grade permit. Pages 1 and 2 should be file.
Department of Health and Mental Hygin important: If tien 27 is marked any injury or other the 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) John 🛨 Canty Nolie Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21205 19a. Informant's Name/Relationship (Type, Print) 1008 Billie Holliday Court Baltimore, Sheila Canty/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 7/30/05 Haltimore, Maryland Mt. zion Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Fugeral Service Licensee 5240 Reisterstown Rd Baltimore, Md 21215 23a. Part 1 Inter the insease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final HYPOXIC INCEPHALOPATHY **Physician** HOURS disease or condition resulting in death) /Medical Examiner TRIAL FIBRILLATION WITH RAPID VENTRICULAR MATE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit DIFICILE COLITIS OSTRIDIUM and Due to (or as a consequence of) the attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23b. Was decedent regnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day detached for 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à **⊉**ZNo 3 Probably 4 Unknown TENSION 1 Yes Be Completed peen VIRUS HEPATITIS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed page MELLITUS TES No DIABE Hospital or Attending Physicien: director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 12 ☐ No 2 ER/Outpatient Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral L Medicai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0063326 MY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MERCY MEDICAL CENTER 301 ST PAULST KUSH DHOLAKIA, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 3 2005 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Reg. No 1 5 2. Date of Death 1 Decedent's Name (First, Middle, Last) JIII Y ^{ay}2005 **Physician** COHEN 3Õ 8:20 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE JEWISH CONVALESCENT CENTER If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12/08/1915 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1□ M 2X F Director 212-30-4493 89 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28e-f show If item 27 le marked other than "netural", or Iteme 23a or 28e-f ebov or other treumatic event, the Modical Examiner must be notified at 1 Yes 2 No MD BALTIMORE BALTIMORE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3131 OLD POST DRIVE 21208 U.S.A. "netural", or Iteme 23a death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 20 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Introcrent: if item 27 is marked other than "natural", or iten any injury or other treumatic event, the Medical Examina and ance. 1 □ Never Married 2 □ Married WHITE 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SALES WOMAN FOOTWEAR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SHERRY LENA ELFONT OTTO ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3131 OLD POST DRIVE - BALTIMORE, MD. 21208 DEBORAH GUSSOW / DAUGHTER 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition
1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State ANSHE' EMUNAH other place) * 4 ☐ Donation 5 ☐ Øther (Specify) 08/02/2005 | BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a, Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDI **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the burial-transit certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760 nding physician Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 You 3 Ectopic pregnancy by the atter Month Day Year 4 Pregnant at time of death 5 Other (specify) be detached Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed þ 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 2 No Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) 1 Yes 2 No Division of Vital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No 1 🗌 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) ပို 2 ☐ ER/Outpatient 3 ☐ DOA completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Mannar of Death Certification: After 1 Natural 5 Pending 2 🗌 No 1 Tyes death. investigation 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier idress of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) AUG 0 3 2005 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene

						Certi	ficate c	of Deat	h		Reg. N	911	5	25209
	DI		1. Decedent's Neme (First, Middle, Las	st)						2. Dete of De Month			Year	3. Time of Death
	Physicia /Medic		MINNIE LEAH COR	BIN						JULY	_	2005		2:45p
	Examin		4a Facility Name (If not institution, give							ocation of Deat	h 4	c. County o		
			FREDERICK VILLA				Williams d Vo		LTIMO		-41-	N/		
	Funeral Director		5. Social Security Number 6. S 219-28-9071 Usual Residence of Decedent	ex 7. Age ☐ M 2☐XF	(In yrs. lest birth		If Under 1 Ye Months Da			8. Date of Bi (Month, Di 9-23-	nn ay, Yea 1914		9. Birth Cour MARY	place (State or Foreign htry) LAND
	and	ŀ	10a. State 10b. County 10c. City, Town or Location										1	0d. Inside City Limits
	Mary	ğ	MD. N/A		BALT	IMOR	RE							1 XYes 2 No
	1 the	Funeral Director	10e. Street and Number				10f. Zip Cod	le			10g. C	Citizen of W	hat Cour	ntry?
	3a o	2	5932 CHARNWOOD				2122	8				USA		
	deat	ner	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U,S.	13. Wa	s Decedent	of Hispanic (Origin? (Sp	ecify Yes or N	0-		- Americ	can Indian, etc.
Maryland 21215-0020	filed within 72 hours efter death with the Maryland Hygiene. wher then "netural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	5	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:			Yes 212(1					Specify:		
5-0	72 hours "netural",	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. I	Deceden	nt's Usual Oc ad of work do NOT use re	cupetion ne during m	ost of work	ing	16b.	Kind of Bus	siness/I <i>n</i>	dustry
2	ithin e e e	현	Elementary/Secondary (0-12)	College (1-4or 5+)			tired)						
7	led w lygier lygier th	S	-12- 17. Father's Name (First, Middle, Last)	-2-		NU	JRSE	18 Mo	ther's Name	e (First, Middle	Maide	HEAL]		KE
anc	ba fi	Be	BENJAMIN CORBIN							MASON	,		7	
Ž	2 should ba f and Mantel h is marked of reumetic eve	ို	19a. Informant's Name/Relationship (1		19b	Mailing	Address (Str			al Route Numi	per. City	v or Town, S	State. Zic	Code)
Z	parmit. Pages 1 and 2 should ba filed within 72 ho Department of Haath and Mantel Hygiene. Important: If Itam 27 is marked other then "netur any Injury or other traumatic event, tra Medical once.		ELOISE CORBIN(S							ORE, M				
	Haal Haal tam 2	ŀ	20a. Method of Disposition		20b. Place of	Dispositi	ion (Name or	f place)	1	Date	20c.	Location - C	City or To	own, State
JO L	ages ent of ft: If if		1 N Burial 2 ☐ Tremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		LOUDON		tory or other RK	piace	8-	3-2005	BAI	LTIMOE	RE. I	MARYLAND
altimore,	nit. F artme ortan Injur	-	21. Signature of Funeral Service Licen					Idress of Fac						
ä	parmit. Departr Imports any inje		1 the	1) Hills	en	17	21-27	N. MC	NROE	ST. BA	LTI	MORE,	MAR	YLAND 21217
		\dashv	23a. Part 1. Enter the disease, or comp	olications that caused t	he death. Do no	ot enter t	the mode of	dying, such	as cardiac	or respiratory	errest,		1	Approximate Intervat Between
	Physician		shock or heart failure. List only	_									 	Onset and Death
	/Medical		Immediate Cause (Final disease or condition	Γ)eme	251	ia							
	Examiner		resulting in death)	D. D.	ue to (or es a c	onseque	ence of):							
	og tis	Medical Examiner		b									1	
	Physician: The law raquiras thet tha death cartificate ba axecuted tribic certificate has been signad by tha attending physician and wal diractor, page 2 should be datached for usa as tha buriel-transit	хап	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D	ue to (or as a co	onseque	nce of):						İ	
68760,	ba a slcian burie	<u>a</u>	cause. Enter Underlying Cause (Disease or injury that initiated events	c									-	
687	ficate I physics that	듛	resulting in death) Lest	D	ue to (or es e co	onseque	rice or):						1	
×	n cartific nding p usa as			d										
. Bo	thet tha death or ad by tha attend datached for us	100 P	Part II. Other significent conditions of	ontributing to death but	not resulting in	the unde	erlying cause	given in Pa	rt I.	23b. Did	tobeco	co use con	tribute t	o the cause of death?
P.0	it tha d by tha tached	چّ	CVA							1 🗆	Yes	2□ No	3□ Pro	bably Junknown
	as the ignad be da	Completed by Physician	CIA									- 1		6.2
ord	raquire been si should	8	HTN							24a. Was	s an aut ormed?	topsy	av	ere autopsy findings ailable prior to impletion of cause
ပို	elawra hasbe ge2sh	ed l											of	death?
<u> </u>	ysician: The l s certificata ha diractor, page	5								10	Yes	2 No	1[☐ Yes 2☐ No
/ita	ilcian: The certificata ractor, pa	Be	25. Was case referred to medical examiner?	Heavital:				26. Pla Other:	ace of Deat	h (Check only	one)			
of C	hysio this c	P_	1 Yes 2 No	Hospital: 1 ☐ Inpatien			3 DOA	ना	Nursing Ho	me 5 Res				(y)
Ę.	fa fa	lon	27. Manner of Death Natural 5 Pending	28a. Dete of Injury (Month, Day	Year) 200. In	jury	M 200. I	njuryat Work? 1 □ Yes 2	□No	200. 200000	11000 111	jury occurre		
isi	Attending ir deeth. ector: Aftai by tha fune	cat	2 Accident investigation 3 Suicide 6 Could not be		y - At home, far	m. street				28f. Location	(Street	and Numbe	er or Rura	al Route Number,
Division of Vital Records,	or Attend aftar deeth Director: /	ertil	4 ☐ Homicide determined	building, etc.	(Specify)	,	, ,			City or To	wn, Sta	110)		
_	To the Hospital or Attendi within 24 hours aftar deeth. To the Funeral Director: A complately filled in by tha fi	Medical Certification:	29a. Certifier Certifying Ph	ysicien: To the best of	my knowledge,	death o	ccurred et th	e time, date	and plece,	and due to the	cause	(s) and mar	nner es s	tated.
	Ho Ho	adic	(Check only 2 Medical Examone)	Iner: On the basis of e and manner stet	examination and ed.	or inves	stigation, in n	ny opinion, d	leath occur	red at the time				
	To the within 2 To the compla	ž	29b. Signature end title of certifier	PHeno	ling		29c. Lic	ense numbe	ər		29d. D	Date signed	(Month,	Day, Yeer)
	~/	/	Kapuwo	Phus	Gan		D	503	303		F	tuG.	Z	2005
	1//	ŀ	30. Name end address of person who	empleted cause of dea	ath (Item 23a) (7	Type, Pri	int)		. 1.	21.2 0	1	(1) (1)		712-0
¥	2		KODOLFO E. F	EUNAND	F, M	0	2	> (~	COLEY	iuc e	9	1776	0 -	121258
	Sta Registr		31. Date filed (Month, AUG o 3	2005 32. Represent	's Signature	4								

DHMH 16 Rev 6/95

			For State Registrar	State of Man		partment of Hertificate of L			ne N2005	25210		
	Physici	an	Decedent's Name (First, Middle, Virgia Mae					2. Date of Death Month Aug. 1,	Day 2005	3. Time of Death 8:34am M		
	/Medic Examin		4a. Facility Name (If not institution, Prince Georges (al		Location of Death		4c. County of Deal	nce Georges		
	Funeral Director		429-42-2486		n yrs. last birthda 78 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 08/19/19	9. Birt 26	hplace (State or Foreign buntry) AR		
	aryland show	J.	Usual Residence of Decedent 10a. State 10b. County GA	Clayton	Oc. City, Town or	Location Forest	t Park			10d. Inside City Limits 1X Yes 2 □ No		
	n the Mi or 28e-f	Funeral Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	ountry?		
	eath wit	eral D	1028 Shieldcres	12. Was Decedent Eve	er in U.S. 13	. Was Decedent of Hi	30297	cify Yes or No-	14. Race - Ame			
920	be filed within 72 hours after death with the Maryland ital Hygiene. dig other than "natural", or Itams 23e or 28e-f show event, I'se Medical Eriar in et mast ke notified at	by	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ※ Maivorced	Armed Forces?	3. 11. 0.0.	. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	n, Mexican, Puerto I Specify:	Rican, etc.)	Black, Whit			
21215-0036	n 72 ho "natur edicel	Completed	15. Decedent's (Specify only highest	grade completed)	(Giv	edent's Usual Occupa re kind of work done of DO NOT use retired	during most of workir	ng 16b	. Kind of Business	Industry		
212	filed within 'Hygiene.'	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)		Homemake	er			Own Home		
Maryland		To Be	17. Father's Name (First, Middle, La Jasper Richmo					(First, Middle, Maid Johnson	den Surname)			
Mary	and and Is m		19a. Informant's Name/Relationship	o (Турө, Print)	19b. Ma	iling Address (Street a			-			
			20a. Method of Disposition 1 □ Burial 2 □ Cremation 3	 		position (Name of ematory or other place	(a)	rate 200	. Location - City or	Town, State		
Baltimore,	artmartm orte inju	i	* 4 ☐ Donation 5 ☐ Other (Spe	cify) = =		nd Cemeter						
ä	Dep Imp		21. Si Jahurerot Funoral Service Li						Home, In timore MD	21230 Approximate		
	Pnysician	0 1	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)									
	/Medical Examiner			b. CONGEST	ionsequence of): INE HE	ART FAI	ILURE					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	·	oneequance of):							
8760,	ate be executed hysician and the burial-transit	Ical Exa	resulting in death) Last	C. Due to (or as a c	consequence of);							
9	artificate ing phys a as the		IF FEMALE:	d								
.O. Box	at the death certific by the attending p tached for use as t	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 [4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	☐Ectopic pregnancy			23d. Date of de Month	ivery Day Year		
9	uires that the signed by a signed by the detaction	by	Part II. Other significant condition	s contributing to death but r	not resulting in the	underlying cause give	en in Part I.	23e. Did tobaco		o the cause of death?		
Records,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed						24a. Was an autopsy performed	? prior to death?	utopsy findings available completion of cause of		
Vital	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	Hospital:	2 ☐ ER/Outpati	Othe	26. Place of Death er: 4 \(\sum \) Nursing Hor		6 Flother (6	-41		
of	ding Phys h. After this funeral dir	on: To	1 ☐ Yes 2 💢 No 27. Manner of Death 1 🛣 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	28b. Time	of 28c. Injury Work	y at 2 k?	28d. Describe how in		cny)		
Division	or Attanding Physician: after death. Director: After this certific In by the funeral director,	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be 200 Place of Injury		M 1 1 1 Street, factory, office	Yes 2 □ No	28f. Location (Stree City or Town, S		ural Route Number,		
	To tha Hospital or Attant within 24 hours after death To tha Funeral Director: completely filled in by the	Medical Ce		Physicien: To the best of exeminer: On the basis of examiner state	kamination and/or							
	To the within To the comple	Me	29b. Signature and title of certifier			29c. License			Date signed (Mont			
	200		30. Name and address of person w	ho completed cause of dea	th (Item 23a) (Tvo		58182	CHEVERL	8-1-6	25		
			DR C. DONALD (31. Date filed (Month, Day, Year)	SEORGE	300/ H	SPITAL 2	DR	CHEVERL	y, MD.	20185		
	Sta Registi		JI. Date filed (Month, Day, Tean)	no completed cause of deal SEURGE 32. Register's 0 3 2005	ever &	Sporte						

			State Registrer	te of Maryland /	Depa Ce	artment of I	leaith a Death	and M	ental Hy	/gier Reg. I	20()5	252	211
			Decedent's Name (First, Middle, Last)						2. Date of De				3. Time o	of Death
	Physicia		William Edward Dunfor	ď					July 2		2005	Year	9:40	τρ ^M
	/Medic Examin		4a. Facility Name (If not institution, give street a			4b. City, Town,	or Location	of Death			4c. County	of Death	12.10	
		•	Country Meadows of Fr	ederick		Frederic	k			F	reder	ick		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last i		If Under 1 Year Months Days	If Under	24 Hrs. Min.	8. Date of Bi (Month, D	rth av. Ye	ar)	9. Birthp	place (State	or Foreign
	Director		225-03-4421 XDM 2	88	Yrs.				June 1	2,	1917	Virg	inia	
Т	pue *		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Lo	ocation			-			1	10d. Inside (City Limits
	sho	ō												s 2 X No
	the N	Director	Maryland Frederick 10e. Street and Number	Freder	ıck	10f. Zip Code				10a.	Citizen of V	Vhat Cour	ntry?	
	with De o					21704				USA				
	leeth	Funeral		s Decedent Ever in U.S.	13.	Was Decedent of	Hispanic Ori	igin? (Spe	cify Yes or N			e - Americ	can Indian,	
' O	r Iten	Fun	1 Never Married 2 Married 1	ned Forces?]Yes_2X]No	-	If Yes, specify Cub			Rican, etc.)			k, White,	etc.	
ဗ္ဗ	al', o	by	3 X Widowed 4 □ Divorced If Ye	es, Give ar or Dates:		1 ☐ Yes 2 🔀 No	Specify:				Specify	Wh:	ite	
, O	72 ho	Completed	15. Decedent's Education (Specify only highest grade comp		a. Dece	dent's Usual Occu kind of work done	pation during mos	t of worki	70	16b	Kind of Bu	siness/In	dustry	
2	thin ?	nple		lege (1-4or 5+)	life.	DO NOT use retire	ed)		3					
7	ygien ygien ser th	Con	12	M	achi	nist	T		(E)				Gover	nment
<u>n</u>	be fill d oth even	Be	17. Father's Name (First, Middle, Last)						(First, Middle	e, Maio	en Sumam	Θ)		
<u> </u>	Men Men Marke Marke	٩	Edward Burley Dunford		SE 84-11*	A 14 (Ch	Haze			07	T	C4-4- 7:-	0-4-1	
Maryland 21215-0036	12 st h and 7 Is n		19a. Informant's Name/Relationship (Type, Pri	4.1		ng Address (Stree								
e,	1 and Healt em 2 ther		Patricia A. Snyder, d. 20a. Method of Disposition	20b. Place	of Dispo	Ball Roa sition (Name of	1		.CK, Ma ate	_	.and Location -	2170 City or To		
ğ	nt of nt of nt of r or o		1 X Burial 2 ☐ Cremation 3 ☐ Remova	I from State	ery, crei	natory or other pla		- 7/2	0/2005			•		
altimore,	permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Maryland Depertment of Health and Mental Hygiene. Importents if Item 27 is marked other than "natural, or Items 23s or 28a-f show surp figury or other treumatic event, the Medical Examinar must be notified at once.		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Park.		Memoria. Name and Address								
Ba	Depert Impo		Rugue M Dance	M009		06 East			-					
			23a. Part1 Enter the disease, or complications shock or heart failure. List only one caus				-				OLION	,, 110	Approxima Interval Be	ate
	Physician		Immediate Cause (Final										Onset and	
	/Medical			nd Stage Demo		a Alzhei	mers	Гуре				Y	ears	
	Examiner		C	hronic Obstr	ucti	ve Pulmo	nary I	Disea	se			Y	ears	
١.	n =	ner	if any, leading to immediate cause. Enter Underlying	ue to (or as a consequenc	ce of):									
	nd rans	Examiner	that initiated events c. H	ypertension								Y	ears	
, 0,	cete be executed chysicien and the burial-translt			ue to (or as a consequenc		T1 ! 1						37		
8760,	ficete be executed physicien and is the burial-transit	dicai	d. <u>C</u>	ongestive He	art	railure			<u> </u>			Y	ears	
9 X	The law requires that the death certificate has been signed by the attending rage 2 should be detached for use as	O .	IF FEMALE: 23c. If v	es, outcome of pregnancy				-			23d Date	e of delive	20/	
Вох	atten for u	cian	in the past 12 months?	Live birth 2 Fetal dea Pregnant at time of death		Ectopic pregnand Other (specify)	y				Mor		,	Year
P.O.	y the	by Physician/M		Unknown									_	
	res that igned b	y PI	Part II. Other significant conditions contributing	g to death but not resulting	in the u	nderlying cause gr	ven in Part I		23e. Did	tobacc	o use contr	ibute to th	he cause of	death?
rds	quires in sig uld bi	q pe	Ischemia, Peripheral	Vascular Dis	ease	, Anemia	,		10	Yes	2 🕅 No	3 🗌 Prob	ably 4]Unknown
00	sw requires been si	ojet	Gastroesophogeal Refl	ıx Disease					24a. Was		24b. V	Vere auto	psy findings	s available
æ	The la	Completed	described in Section 1						auto perfe	ormed 2 🔀 I	? 'd	leath?	2□ No	cause of
ta		BeC	25. Was case referred to medical				26. Place	of Death	(Check only					
>	ystci nis ce direc	10 0	examiner? 1 Yes 2 No Hospita	: 1 ☐ Inpatient 2 ☐ ER/0	Outpatier	nt 3□ DOA Ot	her: 4□Nu	ırsing Hon	ne 5 Res	idence	6 🖔 Othe	er (Specif	y)Asst	.'d
0	Attending Physicien: or death. ector: After this certifici	:uc	27. Manner of Death 28a. 1 X Natural 5 ☐ Pending	Date of Injury 28b (Month, Day Year)	. Time o	Wo			8d. Describe	how in	jury occurre	ed	Livir	ag
S	tendi leath. tor: A the fu	cati	2 Accident investigation				Yes 2	_						
Division of Vital Records,	or Attendented of the Colors o	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e	Place of Injury - At home, building, etc. (Specify)	farm, str	eet, factory, office		2	28f. Location (City or To			er or Rura	.i Route Nur.	nber,
	urs et aral E	Ce	20- Cartifica 4 M Cartifying Physician	T. 16 - 6 - 1 - 1 - 1 - 1 - 1 - 1 - 1				d elecció			/-\		*****	
	To the Hospital or At within 24 hours efter of To the Funeral Direct completely filled in by	edicai	29a. Certifier 1 X Certifying Physicien: (Check only one) 2 Medicel Examiner: Or an											s)
	To the within 2 To the Complet	Me	29b. Signature and title of certifier	7-11	. /	29c. Licen	se number			29d. [Date signed	(Month,	Day, Year)	
	-350		1 Allen K	ully b		D5474	9			Ju1	y 28,	200	5	
1	1		30. Name and address of person who complete	d cause of death (Item 23a) (Туре,						,,			
2	il in the second		J. Allen Reilly, MD,	301 Tollhouse	e Av	enue, Su	ite Di	l, Fr	ederic	k,	MD 2	1701		
	Sta		31. Date filed (Month, Day, Year)	32. Pegistrar's Signature										
	Registr	ar	AUG 0 3 2005	Desce K	do	anti)								

DHMH 17 Rev 1/2001

	L49		1 - For State Registrar	State of	Maryland		artmen			and M		giene Reg. No.	2005	25212	
10 m	Physici /Medi	cal	Decedent's Name (First, Michael David David 4a. Facility Name (If not institute)	Ismael	Font		4b. City.	Town, or	Location o		2. Date of Dea Month July 31	, 20	Year 005 County of Death	2:05 a. M	
	Examir	ner	Prince George 5. Social Security Number	s Hospital	Center 7. Age (In yrs. la		-	ever			8. Date of Birtl (Month, Day	Pr	rince Ge		
	Director		148-66-9880 Usual Residence of Decedent 10a. State 10b. Cour		27	Yrs.					Sep. 22	, 19	77 New	Jersey	
	he Maryla 18a-f ehov	Director	VA	N/A		exand	ria							10d. Inside City Limits 1 Tyes 2 □ No	
92	a within 72 hours after death with the Maryland Ilene. r then "natural", or iteme 23a or 28a-f ehow the Medical Examinar must be maiffied at	Funeral	10e. Street and Number 4331 Duke St. 11. Marital Status 1 ☑ Never Married 2 ☐ M		22312 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Yes 2 No Specify: Puerto Rican					US	0g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: Hispanic				
Maryland 21215-0036	within ane. then	Completed by	3 ☐ Widowed 4 ☐ Divorce 15. Deced (Specify only high Elementary/Secondary (0-12)	16a. Dece (Give life.						16b. Kind of Business/Industry Construction					
ryland 2	outd be filed Mental Hyg arked othe atic event,	To Be Co	17. Father's Name (First, Middle Ismael Font 19a. Informant's Name/Relatio						De1	ia He	(First, Middle,	Maiden Z	Sumame)		
Baltimore, Mar	0 0 = =		Delia Hernande 20a. Method of Disposition **Burial 2 Crematio 4 Donation 5 Other	ez (Mother)	CBI		Duke	St. ne of ther place	#C6_A	Alexa	andria,	VA 20c. Lo	r <i>Town, State, Zi</i> 22312 cation - City or T andale,	own, State	
Balti	permit. Pag Department important: i any injury o		21. Signature of Funeral Service	Licensee Horis			2. Name and 161 I				verly Co , Falls			neral Care 22044	
8760,	Provided and American and Ameri	Ical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a con.equence of): Due to (or as a consequence of): Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):										Approximate Interval Between Onset and Death		
.O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1⊡Live bir 4⊡Pregna	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)					3.		2	23d. Date of deliv Month	rery Day Year	
<u>α</u>	quires that n signed b uld be deta	by	Part in Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1.										the cause of death?		
Vital Records,	The ate h page	Completed									24a. Was a autop perfor	SV	24b. Were autoprior to codeath?	opsy findings available ompletion of cause of 2 No	
o T	Physician: r this certificated director.	To Be	25. Was case referred to mediexaminer? Yes 2 No 27. Manner of Death	Hospital: 1 □ In		R/Outpatier		Othe Bc. Injury Work	9r: 4 □ Nu	rsing Hor	eath (Check only one) Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred				
Division	al or Attending safter death. I Director: After	Certification:	3 ☐ Suicide 6 ☐ Cou	stigation 730	of Injury - At hon g, etc. (Specily)	Injury 11:10 ne, farm, str	РМ	10	(? /es 21) (1	2	SUBJECT 28f. Location (S City or Tow	itreet and n, State)		al Route Number,	
	To the Hospital or within 24 hours after To the Funeral Director completely filled in the Funeral or the Funeral Director Completely filled in the Funeral Completely filled in the Funeral Completely filled in the Funeral Completely Filled in the Funeral Completely Filled in the Funeral Completely Filled in the Funeral Completely Filled in the Funeral Completely Filled in the Funeral Completely Filled in the Funeral Completely Filled in the Funeral Completely Filled In the Funeral Completely	edical (29a. Certifier 1 Certification Check only one)	ying Physician: To the al Examiner: On the ba and mann	best of my know sis of examination	ledge, deat	h occurred vestigation,	at the tim	e, date and pinion, deal	d place, a	and due to the	au e(s)	and manner as	stated. to the cause(s)	
)	To the within 2 To the complei	Me	29b. Signature and title of certi	m.	14		290	OCM.	number E				signed (Month, y 31, 20		
_	H		30. Name and address of personal	ca on. Tin	4 M.D.		Print) 1	11 Pe	enn S	tree	t Balt	imor	e, Mary	land 21201	
	Sta Regist		31. Date filed (Month, Day, Ye.		Grar's Signatu	lire /	Could	6							

			1 = For State Registrar	State of		d / Depa		t of H	ealth a		ental Hyg	iene .g. Ŋ2. (105	25213
	Physicia	an	1. Decedent's Name (First, Middle, Las.								2. Date of Deat	-		3. Time of Death
	/Medic	al	//agus 0 1 2000 0100									3:35P M		
	Examin	er	Copper Ridge Sykesville Carroll											
	Funeral Director			M and	7. Age (In yrs. 81	last birthday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day March 18	Year) 192	9. Bir	thplace (State or Foreign ountry) ennsylvania
	land DW		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	e-fsh	ctor	Maryland Baltimor	e	Timo	onium								1 ☐ Yes P(X) No
	within 72 hours after death with the Maryland ene. than "netural", or items 23e or 28e-f show the Medical Examinar must be maillind at	by Funeral Director	10e. Street and Number 14 Killala Ct				10f. Zip	Code 21093	3		1	-	n of What C	ountry?
	ms 23	nerai	11. Marital Status	12. Was Deced	dent Ever in U	.S. 13.				gin? (Spe	cify Yes or No- Rican, etc.)		Race - Am	erican Indian,
9	or ite	y Fur	1 Never Married 2 Married	Armed Fore 1 ☐ Yes : If Yes, Give	Ž√Ž No		nt Yes, spec 1 □ Yes 🕽		n, Mexican Specify:	, Puerto I	Rican, etc.)	S	Black, Whi _{pec<i>ify:</i> Wh}	_{te, etc.} nite
Ö	hours tural',	ed b	XXWidowed 4 □ Divorced 15. Decedent's Ed	Year or Da	tes:	16a. Deced							of Business	
215	hin 72 3. An "ne Medic	Be Completed	(Specify only highest grad	de completed) College (1-	4or 5+)	(Give	kind of wor DO NOT us	k done d e retired,	luring most	t of workir	ηg	TOD. Killa	Of Dusiness	vindustry
2	ygiene ygiene her tha	Con	Elementary/Secondary (0-12)			H	lomema	ker					wn Hor	ne
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depriment of Health and Mental Hygiene. Importent: If item 27 Is marked other than "netural", or items 23e or 28e-f show appring to other treumatic event, it is Madical Examinar must be multified at once.	To Be	17. Father's Name (First, Middle, Last) Francis Adam Haa	g							(First, Middle, I Mullen	Maiden Su	ımame)	
Mar	d 2 shoth and the and the modern treum		19a. Informant's Name/Relationship <i>(T</i> M. Frances Finnega		ודמ						i um, Mar	-		
	s 1 an if Heal item 2 other		20a. Method of Disposition		20b. F	Place of Dispo								Town, State
<u>E</u>	Page ment o ent: If ury or		XX Burial 2 ☐ Cremation 3 ☐ `4 Donation 5 ☐ Other (Specify			ney Vall	ley Merr	Gard	lens 8		1-		-	Maryland
Baltimore,	permit. Dep rit Import any inj		21. Mature of Funeral Service Coe	Men	Cuas	Ris 22	2. Name an	d Addres			chell-Wie Road Balt			al Home Inc and 21212
	Fnysician /Medical		23a. Part1. Enter the disease, or omp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Demen	tia		er the mod	e of dying	g, such as	cardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death Years
i	Examiner				ary Art		sease	9						Years
A	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		or as a conseq									
	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	or as a conseq	uence of):								
,0928	icate be physicia s the bu	dicai		d										
P.O. Box 6	ath certif tending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		rth 2∐Feta unt at time of d	Ideath 3	Ectopic pr Other (sp					230	d. Date of de Month	livery Day Year
	res that the de igned by the a be detached f	by Ph	Part II. Other significant conditions co	ontributing to de	ath but not res	ulting in the u	nderlying c	ause give	n in Part I.		23e. Did tob	acco use	contribute t	o the cause of death?
rds	w requires been sign should be	ted b									1 □ Ye	s aXX	No 3□P	robably 4 🗆 Unknown
l Records,	The law ra ate has be page 2 sh	Completed					<u> </u>				24a. Was a autops perform	v	24b. Were a prior to death?	utopsy findings available completion of cause of
/ita	ician: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				Oth			(Check only on	e)		
Division of Vital	ding Phyeician: The h. After this certificate ha funeral director, page	n; To	27. Manner of Death	1 Uir	ipatient 2 f Injury n, Day Year)	ER/Outpatier 28b. Time of Injury		8c. Injury Work	4/XIAN		ne 5 Reside			ecify)
sior	lendin eath. or: Aft	catio	XXNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be				М	101	res 2 □ l	No				
Σ	P at 2 in	Certification;	4 Homicide determined	286. Place	of Injury - At hig, etc. (Specil	ome, farm, str fy)	eet, factory	, office		2	28f. Location (St City or Town		Number or R	ural Route Number,
	To the Hospital or Attentwithin 24 hours after deat To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) Z Gertifying Physical Example (Check only one)	ysician: To the iner: On the ba and mann	SIS OF EXAMINA	owledge, death ation and/or in	h occurred vestigation,	at the tim	e, date and pinion, deat	d place, a	and due to the ca	ause(s) ar	nd manner a ace, and du	s stated. e to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	24			290	. License			2		-	th, Day, Year)
			More	/ MD				D00	08318	/		Augu	st 1,	2005
	Oj		30. Name and address of person who o	295 S	toner /	Avenue	Suite	e 307	7 Wes	tmins	ster, Ma	ryla	nd 211	157
	Sta R egistr	-	31. Date filed (Month, Day, Year) AUG 0 3 20	05	ngistrar's Signa	ture A	ale							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Reg. No.2005 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Month Үөаг Physician 2005 8:40 P. August LOUNDS WELCH FLACK /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Future Care-Homewood Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 14, 19 5. Social Security Number Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□M 2XF 90 Yrs. 1915 Mary Land Director 219-28-1387 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or Items 272----- any injury or other treums 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 11☑Yes 2☐No Baltimore N/A Director Maryland Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 21218 123 W. 29th. Street U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 X Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Stôre Sales Clerk 7 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Blanche. Gandy Edward Weston Welch ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (grandson) 2223 Dawn Hill Dr. Charleston, South Carolina William Collier, III 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Aug. 5, 05 Baltimore, Maryland '4 Donation 5 Other (Specify) Loudon Park Cemetery 21. Signature of Funeral Service Licensee Mitchell-Wiedofeld Funeral Home Inc. 6500 York Road baltimore, Maryland 21212 23a. Part 1. Enter the direase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death artery disease **Physician** In Known ronay disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant condition þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Naturat 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place. 29a. Certifier Medical ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D27569 completed cause of death (Item 23a) (Type, Print) Greene Tree Rd

Registrar DHMH 17 Rev 1/2001

State

Division of Vital Records, P.O. Box 68760.

Tenun

. Registrar's Signature

llen

3 2005

31. Date filed (Month L

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 30, 2005 **Physician** :00 Ам JEAN ELIZABETH KAESTNER FOWLER /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center owson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 □ M 2 🔀 F 82 220-18-5235 Director Aug 19, 1922 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location itam 27 is marked other than "natural", or Itams 23s or 28a-f show other traumatic event, the Madical Example must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore County Stoneleigh 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be fited within 72 hours after death with USA 21212 7117 Wardman Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₹ No Specify: Specify: White by 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Residence Homemaker 2 yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be t of Health and Mental I Shields 2 Robert E. Kaestner Alice 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Judie Deakins (Daughter)
20a. Method of Disposition 7108 Sheffield Road, Baltimore, Maryland 21212

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Page Department of Important: If any injury or once. injury or Druid Ridge Cemetery 8/3/2005 Pikesville, Maryland 21. Signature of Funeral Service Licensee

Martin D. Lawson 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between Onset and Death HOUR Immediate Cause (Final disease or condition resulting in death) SEPTIC SHOCK Physician Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death esn 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year detached for 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attanding Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Xinpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA ٩ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mella mio スロッグ D 41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND 21204 OSLER DRIVE, TOWSON, 7601 TOGINDER F. M. D. , MEHTA. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 3 2005 Registrar

			1- For State of Maryland / Department / Department / Department / Department / Department / Depa	artment of Health and Mental Hygic	2005 25216
	Physicia	an	1. Decedent's Name (First, Middle, Last) Dorothy M. Fisher	2. Date of Death Month	Day Year 3. Time of Death
	/Medic		4a. Facility Name (If not institution, give street and number)	August 4b. City, Town, or Location of Death	2 2005 //: 15p M
	Examin	eı	Franklin Woods Center	Rosedale	Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Y	9. Birthplace (State or Foreign Country)
L,	Director		219-18-8517 1 M ALF 85 Yrs. Usual Residence of Decedent		1920 MAryland
	yland yland		10a. State 10b. County 10c. City, Town or Lo	ocation	10d. Inside City Limits
	e Mar sa-fal	ctor	MD Baltimore Perry	Hall	1 ☐ Yes 2 ☑ No
	with th	Funeral Director	10e. Street and Number	21120	g. Citizen of What Country?
	leath v	eral	9820 Redwing Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes or No-	ISA 14. Race - American Indian,
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "netural", or Items 23e or 28a-f ahow aumatic event, the Madrel Examiner must be netified at	by Fun	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 🛣 No	lf Yes, specify Cuban, Mexican, Puèrto Rican, etc.) 1 ☐ Yes 2 ☑ No <i>Specify:</i>	Black, White, etc. Specify:White
21215-0036	2 hou	ted	15 Decedent's Education 16a Dece	dent's Usual Occupation 16	6b. Kind of Business/Industry
2	ithin 7	Completed		kind of work done during most of working DO NOT use retired) emaker	own home
	iled w tygier ther th	Cor	8th 17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Ma	
and	m 0 %	To Be	Walter Lanehart	Gertrude Clau	·
Maryland	shoul	ř	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Maili	ng Address (Street and Number or Rural Route Number, C	City or Town, State, Zip Code)
	and 2 salth a n 27 ls			REnfrew Street Baltim	
Baltimore,	ges 1 t of He If iten or oth		1 Burial 2V Noremation 3 Hemoval from State !	matory or other place)	oc. Location - City or Town, State
ţ	t. Pag rtment rtent: rjury		`4 □Donation 5 □Other (Specify) BayView	crematory 15/05 B	altimore MD
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked any injury or other traumatic evones.		21. Signature of Funeral Service Licensee	_	uneralHomeofEssex
	A .		23a. Part1. Enter the disease, or compleations that caused the death. To not en shock, or heart failure. List goly one cause on each line.	and the mode of dying, such as cardiac or respiratory arrest	ore MD 21221 Approximate Interval Between
	Pnysician	į ,	Immediate Cause (Final disease or condition		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):		
Trate.	Lxammer	-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
J	uted d ansit	Examiner	cause. Enter Underlying		
o,	ate be executed hysician and the burial-transit	Exa	resulting in death) Last C:		
8760,	ate be thysici	dical	d		
9 X	leath certifica attending ph I for use as t	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
. Box	0 0 0	Physician/Med	250. Was deceler pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐	□Ectopic pregnancy □ Other (specify)	Month Day Year
P.0	at the 1 by th stache	Phys	9 Unknowh	20.004	1,
Records,	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part i. 236. Did tobar	cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown
000	aw require is been sig 2 should b	plete		24a. Was an	24b. Were autopsy findings available prior to completion of cause of
Ä	The ate h page	Completed		autopsy performe	
Vital	Physician: The this certificate hirral director, page	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
of	두 두 등	7	1 Yes 2		
O	ding h. After fune	ıtlon	1 Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 □ Yes 2 □ No	,,
Division		Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28f. Location (Stre- City or Town,	et and Number or Rural Route Number, State)
ā	ital or ars afte rel Dire	Cer			
	To the Hospital or within 24 hours afte To the Funerel Discompletely filled in	edical	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, deat 2 Medicel Exeminer: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred at the time, date	e and place, and due to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier		I. Date signed (Month, Day, Year)
•			30, Name and address of person who completed cause of death (Item 23a) (Type,	D53462	8/3/05
	2		30. Name and address of person who completed cause of death (item 25a) (Type,	DAKWOOD ROAD GI	en Pornie, mazioni
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature		1-01
	Registr	ar	AUG 0 3 2005	sale	

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

PORRESTER,

			For State		State	of Maryla	and / Dep				and M	1ental Hy	/gie	ne		
			Registrar 1. Decedent's Name (First, Mid	Idle I ast)			Ce	rtifica	ite of l	Death		2. Date of D	Reg.	No.20	15	25.2.1.8
	Physici		1. Decadent's Name (1 1131, Mile		1 1	L T .	Cadaan					Month	11,	Day 2005	'ear	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institut				Gadson		ly, Town, or	Location of		оиту	' '	4c. County of	Death	8:15 p.
			Future Care	Nur	sina	Home		Ba	altim	ore				V.	1/A	
	Funeral		5. Social Security Number	6. Sex	M 2□F	7. Age (In y	rs. last birthday	Month	er 1 Year s Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	irth ay, Ye	9). Birthp	place (State or Foreign
	Director	1	215-60-7355 Usual Residence of Decedent	1	W 2U F	51	Yrs.					Feb.1	6,	1953	out	M Carolin
	ow at		10a. State 10b. Cour	ty	-	10c.	City, Town or L	ocation							1	0d. Inside City Limits
:	B-f sh	tor	Md.	N/A			Baltin	nore								1 Yes 2 No
7	Z should be filed within 72 hours after death with free Maryland and Menter Hygiene. I show the marked other then "natural", or Items 23a or 28a-f show aumatic event, the Maritical Examples investigation in the marked of the statement of the marked of the statement of the marked of the statement of the marked of the statement o	Director	10e. Street and Number			1		10f. 2	Zip Code				10g.	Citizen of Wh	at Cour	ntry?
	ath w	rail	2811 Clift	on_i	Ave.				212					USA		
	ltems	Funeral	11. Marital Status		Armed F	cedent Ever in orces? 27 No	1 U.S. 13.	Was Dec	edent of Hoecify Cuba	ispanic Ori n, Mexican	gin? (Sp 1, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Black,	Amend White,	
0000	al', or	by F	1 Never Married 2 M 3 Widowed 4 Divorc		If Yes, G	ive		1 🗆 Yes	2/1 No	Specify:				Specify:	Blac	a k
5	ature ical	ted	15. Deced	ent's Educ	ation		16a. Dece	edent's Us	sual Occupa	ation			16t	o. Kind of Busi		
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Bn "r	Completed	(Specify only high Elementary/Secondary (0-12			(1-4or 5+)	life.	DO NOT	vork done d use retired	uring mos.)	t of work	ing				
7	ygien ygien harth it, the	S	12th		N/A		N	1ech	anic					Auto		
מום	ntal H	Be	17. Father's Name (First, Middle Wilton Ga		1									den Sumame)		
<u>خ</u>	hould d Me mark matic	2	19a. Informant's Name/Relatio				10h Mail	ina Addra	es (Street			nia G		SON ity or Town, St	ato Zin	Codel
<u> </u>	of 2 s lith an 27 is r trau		Virginia													Code)
<u>5</u>	f Hea f Hea item otha		20a. Method of Disposition				b. Place of Disp cemetery, cre	osition (A	arne of		2, 1	Date	200	d. 212 c. Location - C	ty or To	own, State
Ē,	Page Tent o		1 Ø Burial 2 ☐ Crematio '4 ☐ Donation 5 ☐ Other		emoval fron	State He	eyden l	-			/16	/2005	So	uth C	arc	lina
= 	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Department of Health and Mental Hygiene in Intropreter; it item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exempler must be notified at Once.		21. Signature of Funral Service			•			and Addres	s of Facilit	y Z			k Hei		
<u> </u>	8 2 E 5 8		Lew	4 6	1. 19	walker	1	ewı	s T.	GWY	nn I	unera	1	Ноте		
			23a. Part1. Enter the disease, shock, or heart failure. L	or complic ist only on	e cause on	each line.	i	1	1			1		٨		Approximate Interval Between Onset and Death
F	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a	1)†		seles	die	Can	dio	VAS	eclan	0	iseas	<	
E	Examiner			1	Due Id	o (or as a cons	sequence of):	1	ind	arel	1					
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	Due	(rasa cons	sequence of):	~ / /	. 11	1						
	cuted nd ransit	Examin	that initiated events	1.	2	2801	rator	4	79	ilar	-					
Š	e exe ian ar urial-t	Ex	resulting in death) Last		Due to	o (or as a cons	sequence of):									
0/0	cate be executed physician and the burial-transit	dicai		d		7									-	
		/Me	IF FEMALE:	25	3c If ves o	utcome of pre	onancy									
S C	atten atten I for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?		1 Live	birth 2 F	etal death 3	□Ectopic □ Other (pregnancy					23d. Date Month		Day Year
į	y the	nysi	1 Yes 2 No 9 Unknown		9□ Unk											
ν, Γ	w requires that the death certify been signed by the attending should be detached for use as	by P	Part II. Other significant cond	itions con	tributing to	death but not	resulting in the	underlying	cause give	n in Part I.		23e. Did	tobac	co use contrib	ute to th	ne cause of death?
necords,	en sig											1 🗆	Yes	2 □ No 3	☐ Prob	ably 4 Unknown
ပ် ပေ	as be	Completed										24a. Was		24b. We	re auto	psy findings available mpletion of cause of
ב =	the sate h page	Con										perf 1 ☐ Yes	ormed 2	de:	ath?	2 No
VICAL	cian: ertific ector,	Be	25. Was case referred to medi examiner?	_	o o nital:				0.11	- 0		h (Check only				
5 8	Physical dir	- To	1 Yes 2 No	l III		Inpatient 2 of Injury	2 ER/Outpatie			4 🖅 NU				e 6 Other		y)
5	ding h. After fune	tlon	1 🗷 Natural 5 🗆 Pen	ding stigation	(Mo	nth, Day Year	njury	M	28c. Injury Work	van ∢? Yes 2.⊟i		200. Describe	now i	injury occurred		
VISION	Atten	ifica	3 ☐ Suicide 6 ☐ Cou	-	28e. Plac	e of Injury - A	t home, farm, si	treet, fact							or Rura	I Route Number,
5	s after or safter or all Director or all Director or or or or or or or or or or or or o	Certification:	4 Homicide		buik	ding, etc. (Sp	ecity)					City or To	wn, S	itate)		
	To the Hospital or Attending Physician: The law requires that the death certificate that in 24 hours after decist. After this certificate has been signed by the attending to the Funatal Director. After this certificate has been signed by the attending completely filled in by the tuneral director, page 2 should be detached for use as	edical	(Check only 2 Medic	ying Phys al Examin	er: On the	basis of exam	knowledge, dea nination and/or in	th occurre	ed at the tim	ne, date an pinion, dea	d place, th occur	and due to the	caus date	e(s) and mann	er as si	ated.
	thin 2 the 1 mplet	Med	one) 29b. Signature and title of certi		and ma	nner stated.			9c. License					Date signed (1
	≥ ≥ E 8	_	Amstur		No	acom			7) /	550	3		_		_	
,	2		30. Name and address of person				Item 23a) (Tyne	, Print)	<i>v'</i>	,	2	:	11	Jus	10	21017
_ (<u>L</u> '		AMBTUN	M		GEEM	501	Do	>1p)	nin	51	Bal	10	o m	0	dialt
	Sta Registr		31. Date filed (Month, Day, Yea	2005	190	Registrar's Si	gnature L	2000	J							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 7 19a b 21 22 per fb 8846 8 3 3 5 6 7 8 1 Hygiene

007			1 - State Registrar		artment of Health and I	Reg. N	000-	25219
34	Physic	ian	1. Decedent's Name (First, Middle, La: Ivan V. Grah	·			ay Year	3. Time of Death - 1723 P M
8.	/Medi Exami		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Deatl	JULY 24,	2005 c. County of Death	1723 P M
*	Examili	ier	2938 W. COLDSPRIM	NG LANE	BALTIMORE CITY		N/Z	
· Æ	Funeral Director			7. Age (In yrs. last birthday) M 2 F 68 67 Yrs.	Months Davs Hours Min.	8. Date of Birth (Month, Day, Yea Aug 15, 1	9 37 Guya	elace (State or Foreign entry) South Lia Amer.
	land ow		Usual Residence of Decedent 10e. State 10b. County	10c. City, Town or Lo	ocation		1	Od. Inside City Limits
	a-fst	ctor	Md. N/A	Baltime	ore			1 ☑ Yes 2 ☐ No
	death with the Maryland ms 23s or 28s-f show	ai Dire	10e. Street and Number 2938 Coldspri	ng Lane	101. Zip Code 21215		itizen of What Cour	ntry?
36	or ite	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	1 ☐ Yes 2 ☐ No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify: Mix	etc.
2-00	72 hours "natural", Idical Exe		15. Decedent's Ec	ducation 16a Dece	dent's Usual Occupation kind of work done during most of work	16b.	Kind of Business/Inc	
Maryland 21215-0036	within	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)			. ,
d 2	al Hygie other vent,		12TH 17. Father's Name (First, Middle, Last)		rity Guard 18. Mother's Nam	wa wa wa wa wa wa wa wa wa wa wa wa wa w	tkins Se	curity
/lan	2 should be and Mental is marked c	To Be	UNKNOWN		UNKN	OWN		
Mar	12 sho h and 7 is mu traum		19a. Informant's Name/Relationship	Type, Print) aham (wife)	ng Address (Street and Number or Ru B. W. Coldsprine Essex Rd. Balto	ral Route Number, City Lane Ba	or Town, State, Zip	Code) Md. 21215
Baltimore, I	ges 1 and 2 it of Health If item 27 or other tra		20a. Method of Disposition 1 Burial 2 Geremation 3 G	20b. Place of Dispo	osition (Name of matory or other place)	_	Location - City or To	
ltim	t. Pa ntmen rtant:		4 □Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	Metro Ci	11- Mal//至	7/05 CA Seph L. Ru	TONSVILI	E MARYLA
B	Depar impo any ir		- Revive	plications that caused the death. Do not enl	2222 W. North Ave	FUNERAL Balto M	d. 21216	215
7, 7	icate be executed by sicien and manifer in the burial-transit with the purial-transit with the purial-	ai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ARTERIOSCLEROTIC CA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of):	ARDIOVASCULAR DISE	LASE		
. Box	death certif e attending od for use as	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year
Δ.	Se us	þ	Part II. Other significant conditions of	ontributing to death but not resulting in the u	nderlying cause given in Part I.		use contribute to th	e cause of death?
of Vital Records,	sician: The law requir certificate has been si irector, page 2 should i	Completed				24a. Was an autopsy performed?	prior to con death?	osy findings available npletion of cause of 2 No
/ita	ysician: is certifica director,	Be	25. Was case referred to medicat examiner?		26. Place of Dea	th (Check only one)	y	
of \	Physician: this certific ral director,	ဥ	1 Yes 2 □ No 27. Manner of Death	Hospital: 1 Inpatient 2 ER/Outpatier 28a. Date of Injury 28b. Time of		ome 5 Residence		SCENE
vision	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: Atter this ocompletely filled in by the funeral dir	Certification:	1 Natural 5 Pending investigation 3 Suicide 4 Homicide 5 Pending determined	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No	28f. Location (Street a City or Town, Stat	nd Number or Rura	l Route Number.
	To the Hospital or within 24 hours afte To the Funeral Director Completely filled in I	Medical C	29a. Certifier 1 Certifying Ph (Check only one) Medical Exer	ysicien: To the best of my knowledge, death iner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the cause(s rred at the time, date ar	s) and manner as sta od place, and due to	ated. the cause(s)
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier	N. It	29c. License number OCME	29d. D. JUI	ate signed (Month, L	
	١		JACK N	completed cause of death (Item 23a) (Type,		ORE, MARYLA	ND, 21201	
	Sta	ite	31. Date filed (Month Out Year) 3 2	005 32. Registrar's Signature	linett o			

05-5157 B.K.S MARIE GANNON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

LE GANNON	V	1- For State of Registrar	Maryland / Dep	artment of Health and rtificate of Death		giene 200 S	5 25220
		Decedent's Name (First, Middle, Last)			2. Date of Dea	ath	3. Time of Death
Physicia /Medic		Harie D. Gra	NNON		Month .TIT.Y	Day Year 30. 2005	1509 P M
Examin	er	4a. Facility Name (If not institution, give street and num. 1 Brett Court # 310	ber)	4b. City, Town, or Location of Di ESSEX	eath	4c. County of De BALTIM	
Funeral Director		219-22-715/ 10M 21 F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year If Under 24 H Months Days Hours M	Hrs. 8. Date of Birth Hin. (Month, Day	y Year) 9. B	irthplace (State or Foreign Country)
land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
Mary a-f eh	tor	MD Baltimore	ESSE	X			1 Yes 2 No
or 28	Director	10e. Street and Number	0 1 -	10f. Zip Code		10g. Citizen of What (Country?
e 23a		1 Brett Court,	Hpt. 310	21221		USA	
17215-0036 within 72 hours after death with the Maryland ene. then "natural" or iteme 23s or 28s-f ehow then "Medical Examinat must be recitifed at	by Funeral	11. Marital Status 1 Never Married 2 Marned For 1 Yes If Yes, Give Year of Date of the Company	2 Mo	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pt 1 ☐ Yes 2 ☑ No Specify:	' (Specify Yes or No- uerto Rican, etc.)	14. Race - An Black, Wh Specify: W	. 1 . 1
5-0036 72 hours at "natural", or patent	Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during most of	workina	16b. Kind of Busines	s/Industry
within then	dmo	Elementary/Secondary (0-12) College (1-	4or 5+) life.	DO NOT use retired)		Lega	./
N DO	BeCc	17. Father's Name (First, Middle, Last)		Secretary 18. Mother's 1	Name (First, Middle,		
/land	To B	Edward J. Conway		Geri	Leude O	Hare	
Mary d 2 shou th and M th and M traumati		19a. Informant's Name/Relationship (Type, Phint)	4	ng Address (Street and Number or		r, City or Town, State,	Zip Code)
C = (4 F		2010 res M. Hoftman - David 20a. Method of Disposition	20b. Place of Dispo	sition (Name of		20c. Location - City of	21085
Page ento		1 ☐ Burial 2 【2 Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)		matory or other place)	,	_	11
Baltil permit. I Depertm Importa		21. Signature of Funeral Service Licensee	22 32 32 32 32 32 32 32 32 32 32 32 32 3	Name and Address 1 Facility	1451 1,2005_	Daltman	200
D 89889		- Hiter S. asset		Name and Address & Facility Bradley - Ashto. 2134 W. 1100 5	VING Rd.	2/222	. / / .
		Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea Immediate Cause (Final	used the death. Do not en ch line.	er the mode of dying, such as care	diac or respiratory arr	est, Environmenta	Approximate Interval Between Onset and Death
Physician / /Medical		disease or condition resulting in death)	levotic Cardiova	scular Dispase Con	nplicated by	Hyperthermin	4
Examiner			i as a consequence or):				
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	iner	if any, leading to immediate Due to (classe. Enter Underlying	r as a consequence of):			-	
be executed icien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (c.	r as a consequence of);				
8760, Astronomy and the burial-transit	dicai E	d					
8 8 8	a ⊢	IF FEMALE:					
death certifications of for use as	ian/	23b. Was decedent pregnant in the past 12 months?	ome of pregnancy th 2 Petal death 3	Ectopic pregnancy		23d. Date of de Month	elivery Day Year
COFGS, P.O. BOX of wrequires that the death certification is good by the eltending should be detached for use as	Physician/M	1 ☐ Yes 2 No 4 ☐ Pregna 9 ☐ Unknown 9 ☐ Unknown		Other (specify)		Month	Day (ear
S, F	by Pt	Part II. Other significant conditions contributing to dea	ath but not resulting in the u	nderlying cause given in Part I.	23e. Did tol	bacco use contribute	to the cause of death?
Ords, Frequires that					1 🗆 Yo	es 2,200 3 F	Probably 4 DUnknown
40 00 OI	Completed				24a. Was a autops	sv prior to	autopsy findings available completion of cause of
_ F # 60					perform 1 Yes	med? death?	s 2 No
OT VITAL Physician: T this certitical ral director, ps	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 In	patient 2 ER/Outpatier		Death (Check only on		AT SCENE
On Or VIIa ding Physician: th. After this certitor funeral director.	⊢ ∤	27. Manner of Death 28a. Date of		A Nursini	28d Describe by	ow injury occurred	ecify) AT SCENE
Attending r death. ector: Alter by the fune	catio	2 Accident investigation		9PM 1□Yes 2No	air condi	in home u	лчиош
DIVISION Jor Attending after death. Director: After d in by the fune	Certification:	/3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of building	of Injury - At home, farm, str g, etc. (Specify)	eet, factory, office	City or Town	treet and Number or F n. State) Breh	Rural Route Number,
• Hospitel or / • 24 hours after • Funerel Dire letely filled in b		29a. Certifier 1 Certifying Physician: To the t	pest of my knowledge, death	occurred at the time, date and old	ESSEX, W	11) 2122	1
LIVISION To the Hospitel or Attention within 24 hours after deat to the Funerel Director: completely filled in by the	edicai	(Check only one)	ils of examination and/or in	vestigation, in my opinion, death of	ccurred at the time, d	ate and place, and du	e to the cause(s)
To the within 2. To the complet	Σ	29b. Signature and title of certifier	Ma	29c. License number	2	9d. Date signed (Mor	
Λ .		Alcored		O.C.M.E		AUG. 1,	2005
. /		30. Name and address of person who completed cause	or death (Item 23a) (Type, 111 PEN	N STREET, BALTIM	ORE, MARYL	AND 21201	
Sta		31. Date filed (Month, Day, Year) 32. Re	gistrar's Signature	<i>V.</i> .			
Registra	ar	AUG 0 3 2005	U SO. 19084				

				•		Department of H		-	•	
		•	1 - For State Registrar	Otato of Ma	y land /	Certificate of L			2005	25221
	Dhorisi		1. Decedent's Name (First, Middle, Last)	i b				2. Date of Death Month	Day, Year	3. Time of Death
	Physicia /Medic		young B.	Han				07	29 2005	
	Examin	er	4a. Facility Name (If not institution, give st Howard County	treet and number)	Hos	hital	Location of Death		4c. County of Dea Howard	th
	Funeral		5. Social Security Number 6. Sex.	7. Age	(in yrs. last b	pirthday) If Under 1 Year	ia, If Under 24 Hrs.	8. Date of Birth		thplace (State or Foreign
L	Director		214-78-2687	M 2□F	75	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day,) 01/1//	(19)30 Ko	thplace (State or Foreign ountry) Yea
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City. To	wn or Location				10d. Inside City Limits
	Maryl -f sho	tor	MD Howard		Woods					1 Tes 2 No
	th the	irec	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Co	ountry?
	death with the Maryland ms 23a or 28e-f show prives be mailthed ut	Funeral Director	10306 Winstead (2116			USA	
	itema itema	une	11. Marital Status 1. Never Married 2 Married 1. Married 2. Married 1. Marri	2. Was Decedent Ev Armed Forces?		13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spec In, Mexican, Puerto P	cify Yes or No- lican, etc.)	14. Race - Ame Black, Whit	
920	el', or	by	X□XWidowed 4 □ Divorced	1 ☐ Yes XX No If Yes, Give Year or Dates:	,	1 □ Yes 2 X 1X1o	Specify:		Specify: AS	ian
2	filed within 72 hours after Hygiene. ther then "naturel", or Ite ont, the Medical Exant or	Completed	15. Decedent's Education (Specify only highest grade	ation completed)	16	ia. Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	ation during most of workin	g 16	5b. Kind of Business	/Industry
21	within ane. then '	ldm	Elementary/Secondary (0-12)	College (1-4or 5+) 1	life. DO NOT use retired Business Ow			Dry Clea	ning
2	2 should be filed within 72 hours after death with the Marylar and Mental Hyglene. Is marked other then 'naturel', or items 23a or 28e-f show eumetic event, the Madical Examinating the rodified at	Be Co	17. Father's Name (First, Middle, Last)	4	1	Justiness on	18. Mother's Name			
/lan	uld be Mental Irked o	To B	Sang Ok Han				Young	Shil R	О	
Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship (Type Christina Park			9b. Mailing Address <i>(Street a</i>	and Number or Rural	Route Number, C	City or Town, State,	Zip Code) ID 20759
	1 and Health em 27 ther ti		20a. Method of Disposition	(uaugnte					Oc. Location - City or	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Importent: If Item 27 Is marke any injury or other treumetic ones.		A Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Cres	of Disposition (Name of tery, crematory or other plac tlawn Memor	e) ial 08/0	1/05 M		sville, MD
a E	permit. Page Department of Importent: If any injury or once.		21. Signatur of uneral Service Licenses	θ // -		22. Name and Address	<u>i</u>			omes, Inc.
<u> </u>	permi Depa Impo any ii		Awendo yo	Temming		5555 Twin	Knolls	Rd. C	olumbia,	MD 21045
			23a, Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused to e cause on each line	he death. De	110 (2.00) (2.00) (2.00)			it,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Meta	stuc	ic hung	Canc	er.		2 mos
	Examiner		f .	Brown	n n	retastase	5			2mos
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a	consequenc	e of):				1
	sician and burial-transit	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a	consequence	effusion				week
760,	ite be executed iysician and ne burial-transit	calE		00010 (0) 0000						
89										
ě	death certifica e attending ph d for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome o		th 3 Ectopic pregnancy			23d. Date of de Month	livery Day Year
.O. Box	it the death certifica by the attending ph tached for use as th	by Physician/Med	1 Yes 2 No	4 Pregnant at ti 9 Unknown	ime of death	5 Other (specify)				July 132.
<u>a</u>	The taw requires that the tee by the bas been signed by the bage 2 should be detache	y Ph	Part II. Other significant conditions cont	tributing to death but	not resulting	g in the underlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
rds	w requires that been signed b should be deta							1 XYes	2 □ No 3 □ P	robably 4 Unknown
Records,	e taw re has be je 2 sho	Completed				<u> </u>		24a. Was an autopsy	prior to	utopsy findings available completion of cause of
								performe	od? death? No 1 ☐ Yes	2 No
Ž	s certif	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 XInpatien	+ 2□ EB/	Other	26. Place of Death er: 4 ☐ Nursing Hom	, , , , , , , , , , , , , , , , , , , ,		
o c	Attending Physicien: r death. ector: After this certifics by the funeral director, I	-	27. Manner of Death	28a. Date of Injury (Month, Day		Time of 28c. Injury Work	y at 2	Bd. Describe how		Спу
Sior	endin eath. or: Afi	atlo	1 Avatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(month, bay	, 500/		Yes 2 □ No			
Division of Vital	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, (Specify)	farm, street, factory, office	2	8f. Location (Stre City or Town,	et and Number or R. State)	ural Route Number,
_	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Physi	ician: To the best of	my knowled	ge, death occurred at the tin	ne, date and place, a	nd due to the cau	ise(s) and manner as	s stated.
	he Ho in 24 h he Fu pletely	edical	(Check only 2 Medicel Exeminations)	er: On the basis of e	examination a	ge, death occurred at the tin and/or investigation, in my o	pinion, death occurre	d at the time, dat	e and place, and due	e to the cause(s)
	To the To the comple	Ž	29b. Signature and title of certifier	~		29c. Licenso			d. Date signed (Moni	-
1	(1)		Driee M.		ath (Item 02-	V Truce Briest	4413		07-29-	aus
1	+		30. Name and address of person who con	ee 30	0/5.	a) (Type, Print) Hanover	St. B.	altim	ore MD	21225
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	r's Signature					
40	Registr	ar,	AUG 0 3 20	005	. 1	& Smartes				

DHMH 17 Rev 1/2001

ORIGINAL

Lola H. Hasson 05-5101 AKG

-510 }	L		State of Maryland / Department of Health and N State Unpend Item 23a-c,pt.II,27,28a-t per me C846 8-16- Registrar	lental Hygie 05 tas	ne	
44	e dig		Hegistrar - Continuate of Death Decedent's Name (First, Middle, Last)	2. Date of Oeath	5003	3. Clime of Death 2
	Physici /Medi		LOLA VIRGINIA HEAPS HASSON	Month July 28	3, 2005	10:23 P ^M
1	Examir	_	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	
			8822 Walther Blvd #1611 Parkville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Baltimore 9 Birtho	
610	Funeral Director		213-14-5069 1 M 2 T F 85 Yrs. Months Days Hours Min.	June 23.		lace (State or Foreign try) Land
<u>e</u>	pu &		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			0d. Inside City Limits
	Manylan f ehow	Į.			'	1 ☐ Yes 2 No
	r 28a-	rect	Maryland Baltimore County Parkville 10e. Street and Number 10f. Zip Code	10g.	. Citizen of What Coun	try?
	ath with the Maryla i 23a or 28a-f ehov	Funeral Director	8820 Walther Blvd, Apt 1611 21234		USA	
	ter dea	uner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	g 0 5	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 257 No If Yes, Give X 1 ☐ Yes 257 No Specify: X 1 ☐ Yes 257 No Specify: X		Specify: Wh	ite
5-0036	72 hours neture!;		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work	160	b. Kind of Business/Inc	
2121	i within 72 ho liene. r than "netur Ine Medical	Completed	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	m'g		
2	il Hygier other ti		2 yrs Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, Mai	Railroad	
Maryland	d fa b	To Be		ay Mason	,	
ary	2 shou and M ie mar eumat	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run		ity or Town, State, Zip	Code)
	2 4 5 E		Mr. Donald G. Robinson (P.R.) 5716 Bradley Road, No.	th Olmste	ead, Ohio	44070
lore	0, 0		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)	Date 20d	c. Location - City or To	wn, State
Baltimore,	permit. Page Department of Important: If eny injury or		4 Donation 5 Other (Specify) Parkwood Cemetery 8/5/2 21. Signature of Funerate serving (Segree) 22. Name and Address of Facility	2005 Pa	arkville, N	Maryland
Ba	permit. Departr Importa eny inj		Mitchell-Wiedefold	Funeral I	Home, Inc.	. 0.1.0
F			Martin D. Lawson 6500 York Road, Ba 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arrest,	Maryland Z.	Approximate Interval Between
	Physician		disease or condition Excanguination			Onset and Death
	/Medical Examiner		Due to (or as a consequence of):			
	- gr 20	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	cuted	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events c. End stage renal disease			
0,	e exertien ar urial-t	Exa	resulting in death) Last Due to (or as a consequence of):			
8760,	icate be executed physicien and s the burial-transit	dlcai	d			
Box 6	or Attending Physician: The law requires that the death certifis the death. Director: After this certificate has been signed by the attending to by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23b. Was decedent pregnant		23d. Date of delive	ry
m	ne death the atte	sicia	in the past 12 months? 1 Yes 2 No		Month	Day Year
P.O.	that the di ed by the detached	Phys	9 Unknown \ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	22a Did tabaa	cco use contribute to the	to square of death?
d's	signed d be del	d by	Hypertension; hypercholesteroiemia	1 ☐ Yes		ably 4 □Unknown
Division of Vital Records,	w requir been si should	Completed		24a. Was an	24b. Were auto	psy findings available
Re	The lav	ошо		autopsy performed Yes 2	d? prior to cor death?	npletion of cause of 2□ No
'ital	sician: The certificate hi rector, page	BeC	examiner?	h (Check only one)		
of V	Physic this co	၉	XXI Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Ho		e 6 MOther (Specify	at scene
on	ding Ph h. After th funeral	Certification:	1 Natural 5 Pending (Month, Day Year) Injury Work?	28d. Describe how	injury occurred U	шк
visi	Attener deat	ifica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Stree	at and Number or Rura	I Route Number,
Ö	tel or rs afte al Dir	Cert		Parkville	e, MD Wal	ther Blvd.
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (prescont) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (prescont) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the caus red at the time, date	se(s) and manner as si and place, and due to	ated. the cause(s)
	To th within	Me	29b. Signature and title/of certifier 29c. License number O. C. M. E.	29d.	Date signed (Month, July 29, 2	
	L. Brut		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
5	O No		J. LAKON LOCKE (M) 111 Penn Street, Ba	altimore,	Maryland 2	21201
#. ₃	Sta Regist		31. Date filed (Month, Cay, Year) AUG 0 3 2005 A. Registrar's Signature			

			State of Maryland / De		Mental Hygi	ene	
			Togram 2	ertificate of Death		g. No 1 1 5	25223
ı	Physici /Medio		1. Decedent's Name (First, Middle, Last) Marian B. Hughes		2. Date of Death Month August	2, 2005	3. Time of Death 12:10p M
}	Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	th	4c. County of Death	
			Carroll Lutheran Village S. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Westminster Westminster If Under 1 Year If Under 24 Hrs	R Date of Ridh	Carrol	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 212-24-6164 78 Yrs.	Months Days Hours Min.		Year) 9. Bitt	nplace (State or Foreign untry) 1D
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Maryi -f ehc	tor	MD Carroll Sykes	ville			1 X Yes 2 □ No
	ith the	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	untry?
	ath w	ral	7616 Maple Avenue	21784		USA	Anna Badina
	iteme	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 1 □ Yes	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 	to Rican, etc.)	14. Race - Amer Black, White	
920	filed within 72 hours after death with the Maryland Hygiene. other than "naturel; or Iteme 23e or 28e-f ehow ent, the Medical Eraminer must be notified at	by	3 ☐ Widowed 4 🛣 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Wh	nite
2 2	72 ho	eted	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gir	edent's Usual Occupation re kind of work done during most of wo . DO NOT use retired)	rking	6b. Kind of Business/l	ndustry
121	within ene. then '	Completed		Bookkeeper/Cashier		Clerical	
d 2	e filed I Hygi other	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Na	me (First, Middle, M	aiden Sumame)	
Maryland 21215-0036	should be ind Mental I	To E	William Brandenburg, Sr.		se Berry		
Mar	12 she h and 7 is m treum		19a. Informant's Name/Relationship (Type, Print) (Daughter s ^{19b. Ma} Barbara Leasure, Carol Hall 765				ip Code)
<u>.</u>	Health Health tem 27 i		20a Method of Disposition 20b. Place of Dis	16 Maple Avenue Sy		Oc. Location - City or 1	Town, State
<u>o</u>	Pages nent of ant: if its arry or o		1 V Burial 2 I Cremation 3 I Hemoval from State 1	ematory or other place) Leld Cemetery 8/6/	2005 S	ykesville,	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel; or iteme 23e or 28e-f show any injury or other treumatic event, the Medical Examination must be notified at once.		21. Signature of Funeral Service Licensee	A Name and Address of Facility HOM	IE & CHAPE	L, PA (Box	: 195)
	20 E 2 3			Sykesville, MD 217	84 (410)-	795-1400	Approximate
			shock, or heart failure. List only one cause or any line.	a.	c or respiratory arres	st,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of):				IWE
n	Examiner		Sequentially list conditions, b.				
	ped tist	lner	if any, leading to immediate cause. Enter Underlying Cause (Disease or highly)				
	te be executed ysician and te burial-transit	Examiner	that initiated events c. Pue to (or as a consequence of):				
1260	ate be executed hysician and the burial-transit	cal	d.				
89 x	ertifica ling ph	Physician/Med	IF FEMALE:			1	
Вох	death certifica attending ph for use as t	cian/		☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delin	very Day Year
o.	the d	hysle	1 ☐ Yes 210 No 9 ☐ Unknown				
s, D	The law requires that the death certifics tie has been signed by the attending phage 2 should be detached for use as the	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to	
ord	w require been si should I	ted	Ensomerry Concer	1-1		2 □No 3 □ Pro	
Records,	has b	Completed	Enteroculaneous fel	rusa	24a. Was an autopsy perform	prior to c	opsy findings available ompletion of cause of
Vital			25. Was case referred to medical	26. Place of De	1 ☐ Yes 2		2X No
	Physicien: r this certifica ral director, I	To Be	examiner? 1 Yes No Hospital: 1 Inpatient 2 ER/Outpati	Other \/		ce 6 □Other (Spec	ify)
Division of	ng Ph kter th uneral		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time (Month, Day Year)	Work?	28d. Describe how	injury occurred	
Sio	deat deat stor: / the	cat	2 Accident investigation 3 Suicide 6 Could not be e. Place of Injury - At home, farm, s	M 1 ☐ Yes 2 ☐ No	28f. Location (Stre	et and Number or Rui	ral Route Number.
<u>></u>	P Sign	Certification:	4 Homicide determined building, etc. (Specify)	eroot, lactory, office	City or Town,		
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled In		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or	ith occurred at the time, date and place	e, and due to the cau	ise(s) and manner as	stated.
	the H thin 24 the F mplete	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number		d. Date signed (Month)	
•	T wil	_	7			5/2/2	005
	ix		30, Name and address of person who impleted cause of death (Item 23a) (Type	H00558 5T. LUKE C		IN EST N	HINSTER
			KEUIN BREWSTER, 200	ST. LUKE C	iRCLE,	MD	21158
	Sta Registr		31. Ďate filed (Month, Day, Year) AUG 0 3 ZUUD	whi.	/		
		4					

Physician /Medical Examiner

Funeral Director

State Registrar	State of Man			cate of E					NoO ()	OE	25021
1. Decedent's Name (First, Middle, Last) GRADY HUGHES)		-				2. Date of I	,	Day 31 2	Year	Time of Death
4a. Facility Name (If not institution, give a	street and number)	ITAL		City, Town, or SALT I					4c. Count		
5. Social Security Number 6. Sec. 17.		n yrs. last birth		Inder 1 Year oths Days	If Under 2 Hours	24 Hrs. Min.	8. Date of E (Month, I	Day, Yo		Cou	place (State or Foreig ntry) RYLAND
Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town)							10d. Inside City Limits
MD • N/A		DALIL		f. Zip Code				10g	. Citizen of	What Cou	
2319 N. MONROE				212		1.6.17		l Na	US.		ican Indian
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates:	er in U.S.	Was Decedent of Hispanic Origin? (Siff Yes, specify Cuban, Mexican, Puerton Till Yes 2√1, No Specify:				pecify Yes or No- o Rican, etc.) 14. Race - / Black, V Specify:			ack, White,	
15. Decedent's Edu (Specify only highest grad	ucation de completed)	((Give kind o	Usual Occupa of work done of OT use retired,	uring most	t of work	in <i>g</i>	16	6b. Kind of E	Business/Ir	ndustry
Elementary/Secondary (0-12) -8-	College (1-4or 5+) -0-	FIRS		ADE ENG	INEER		(First 44)-1	10 14-	STAT		
17. Father's Name (First, Middle, Last)					1176		e (First, Midd	⊔ю, Ма	и ов п <i>Sum</i> a	ine)	
JIM HUGHES 19a, Informant's Name/Relationship (T)	vpe. Print)	19b.	Mailing Add	dress (Street a			AYNES a <i>l Route Nur</i>	nber, C	City or Town	n, State, Zij	ip Code)
MILDRED HUGHES (W				N. MONR							
· T all	MAHTANOL			ORIAL P	s of Facilit	PHI	LLIPS	FUN	ERAL	HOME,	
23a. Part1. Enter the disease, or compositors, wheat failure. List only of immediate Cause (Final disease or condition resulting in death)	olications that caused the cause on each line. a Due to (or as a cause)	MONA	172] not enter the PRY	ne and Address 1-27 N. a mode of dyin	MONI g, such as	ROE cardiac	LLIPS ST. BA or respirator	FUN LTI y arres	MORE,	HOME, MARÝ	
23a. Part1. Enter the disease, or compositock, oneart failure. List only of Immediate Cause (Final disease or condition	b. Conce Due to (or as a concern of the concern of	MONA consequence of STIVE CONSEQUENCE OF	HEY TRY TRY TRY TRY TRY TRY TRY T	me and Address 1-27 N. a mode of dyin ART F	MONI g, such as	ROE cardiac	LLIPS ST. BA or respirator	FUN LTI y arres	MORE,	HOME, MARÝ	P.A. YLAND 2121 Approximate Interval Between
23a. Part1. Enter the disease, or compshock, otheart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CONGE Due to (or as a congress of the congr	MONA consequence of STAGE consequence of STAGE consequence of STAGE consequence of STAGE pregnancy	172] 172] 1RY 1RY 1RY 1RY 1RY 1RY 1RY 1R	me and Address 1-27 N. a mode of dyin ART F	MONI MONI g, such as EMA EAL	ROE cardiac	LLIPS ST. BA or respirator	FUN LTI y arres	TENAL MORE,	HOME, MARÝ	, P.A. YLAND 2121 Approximate Interval Between Onset and Death
23a. Part1. Enter the disease, or composhock, defeart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	blications that caused the one cause on each line. a. PULCA Due to (or as a cause) Due to (or as a cause) C. Due to (or as a cause) Due to (or as a cause)	MONA consequence of STAGE consequence of STAGE consequence of Pregnancy Fetal death not resulting in	172] Anot enter the PRY of): HEY of): RE of): Of): Of): The property of the property o	me and Address 1-27 N. e mode of dyin EDE ART F ENAL ppic pregnancy er (specify)	MONI MONI g, such as EMA PAL	PPHI ROE cardiac	LLIPS ST. BA or respirator	FUNITIES	TENAL MORE,	HOME, MARY	P.A. YLAND 2121 Approximate Interval Between Onset and Death Very Day Year
23a. Part1. Efter the disease, or composhock, denear failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	blications that caused the one cause on each line. a. PULCA Due to (or as a cause) Due to (or as a cause) C. Due to (or as a cause) Due to (or as a cause)	MONA consequence of STAGE consequence of STAGE consequence of Pregnancy Fetal death not resulting in	172] Anot enter the PRY of): HEY of): RE of): Of): Of): The property of the property o	me and Address 1-27 N. e mode of dyin EDE ART F ENAL ppic pregnancy er (specify)	MONI MONI g, such as EMA PAL	PPHI ROE cardiac	LLIPS ST. BA or respirator S. H' S. E.	FUNILTI y arress YPC	23d. C	Date of delimentaribute to	P.A. YLAND 2121 Approximate Interval Between Onset and Death Very Day Year obably 4 Unknow topsy findings availate completion of cause of
23a. Part1. Enter the disease, or compshock, otheart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	bilications that caused the cone cause on each line. a. PULL Due to (or as a cone to cone cause on each line. b. CONGE Due to (or as a cone cone cause) C. Due to (or as a cone cone cone cone cause) Due to (or as a cone cone cone cone cone cause) 23c. If yes, outcome cone cone cone cone cone cause) Unknown ontributing to death but	MONA consequence of STAGE consequence of STAGE consequence of Pregnancy Fetal death not resulting in	172] Anot enter the PRY of): HEY of): RE of): Of): Of): The property of the property o	me and Addres 1-27 N. e mode of dyin E O C ART F EINAL opic pregnancy er (specify) tying cause giv	MONI MONI g, such as EMA DIS	PHI ROE cardiac	LLIPS ST. BA or respirator SE 23e. D 1 24a. V a p 1 □ Ye th (Check or	FUNITI y arress	23d. C	Date of delination tribute to a prior to c death?	P.A. YLAND 2121 Approximate Interval Between Onset and Death Very Day Year the cause of death? obably 4 Unknow topsy findings availate completion of cause of 2 No
23a. Part1. Enter the disease, or compshock, defeart failure. List only of shock, ailure. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the condit	blications that caused the one cause on each line. a. PULL Due to (or as a complete of the c	MONA Consequence of TAGE Consequence of Petal death me of death TO R TO PETAL DE CONSEQUENCE OF PETAL DE CONSEQUENCE OT	172] and enter the PRY of): REP of): 3 Ecto 5 Oth attractiont 3	me and Addres 1-27 N. e mode of dyin EDENAL Dopic pregnancy er (specify) dying cause giv 28C. Injur Wor	MONII MONII	ROE cardiac	LLIPS ST. BA or respirator H SE 23e. D 1 24a. W a 1 □ Ye	FUNITI y arress	23d. C. N. 23d. C. N. 23d. C. N. 24b. 24b. 29b. 24b. 29b. 24b. 29b. 20b. 24b. 29b. 20b. 20b. 20b. 20b. 20b. 20b. 20b. 20	Date of dein Annth ontribute to a pror to c death?	P.A. YLAND 2121 Approximate Interval Between Onset and Death Very Day Year the cause of death? obably 4 Unknow topsy findings availate completion of cause of 2 No
23a. Part1. Enter the disease, or compshock, otheart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a decomposition of the course on each line. a. Due to (or as a decomposition of the course on each line. Due to (or as a decomposition of the course of th	A consequence of STAGE consequ	172] not enter the PRY of): RE of): 3 Ecto 5 Oth the underly intpatient 3	me and Address 1-27 N. e mode of dyin EINAL Depic pregnancy her (specify) dying cause giv 28c. Injur Model 10	MONI g, such as A A A A A A A A A A A A A	ROE cardiac	23e. D 24a. V a p 1 Ve th (Check or ome 5 F 28d. Descrit	FUNITI y arress	23d. C. N. 24b. 24b. 200. V. injury occurrent and Nur	Date of delimentaribute to a protoco death? Other (Specurred	P.A. YLAND 2121 Approximate Interval Between Onset and Death Very Day Year the cause of death? obably 4 Unknow topsy findings availate completion of cause of 2 No

State

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD

31. Date filed (Month, Day, Year) AUG 0. 322785 Fran's States.

BALTIMORE, MD 21239

THE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

أنكرا	MA HUNI	.EK	1- For State Registrar	te of Maryla		artment of F rtificate of	lealth and M <i>Death</i>		jiene eg. No. 2	000	0000
	44.17	9	Decedent's Name (First, Middle, Last)					2. Date of Dea	th	003	3-Time of Death
	Physici /Medio		Thelma Victoria Hu	nter				JULY	24, 2	005	11:17 A ^M
	Examir		4a. Facility National Strains of the Strain and American American Strain and American American Strain and American A	nd number)		BALTIMO	RE CITY		4c. Coi	unty of Death	
Age*	Funeral		5. Social Security Number 6. Sex		rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 10-3-	, Year)	9. Birthpl Coun	ace (State or Foreign try)
*	Director		216-54-0791		39 ^{Yrs.}			10-3-	65	MD	
	land ow		10a. State 10b. County	10c.	City, Town or La	cation				10	Od. Inside City Limits
	Man Ff sh	tor	MD	J	essup,	1D					1 ☐ Yes 2 No
	th the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen	of What Coun	try?
	death with the Maryland ms 23a or 28a-f show I must en notified at	aiD	2825 Boarman Ave.			21215	5		USA		
	r dea	Funeral	Am	s Decedent Ever in led Forces? Yes 2 ☐No	n U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - America Black, White, 6	
20	s afte	by Fi	If Y	es. Give		1□Yes 2█No	Specify:		Spi	ecify: Bla	ck
2-003p	72 hours after natural', or ite		15. Decedent's Education	r or Dates:	16a Decer	dent's Usual Occup	ation		16b Kind	of Business/Ind	luctor
N N	in 72	Completed	(Specify only highest grade comp		(Give	kind of work done OO NOT use retired	during most of work	ang	TOD. Talle	51 0 4311103 3 41110	out y
Z	d within giene. or then "	E O	Elementary/Secondary (0-12) Col 10th	lege (1-4or 5+)	Nursi	ing Assi	istant]	Hospi	ital	
	al Hygie I other I	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Sur	mame)	
yland	should be nd Mental marked o	To	Braxton B. Hunter				Thelma	Richard	dson		
Mar	and mu		19a. Informant's Name/Relationship (Type, Pri	,	110		and Number or Run				Code)
e,	l and 2 Health in 27 i		Dorather Blackwell 20a. Method of Disposition	(aunt)			an Ave.			21215 ion - City or To	- Chair
	it it		1 Burial 2 □ Cremation 3 □ Remova	I from State		sition (Name of natory or other place					
Банттог	artme ortant Injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Septice Licensee	1	acred H		ss of Facility We			alk,MD	
מ	permit. Pages 1 and Department of Healtmportant: if Item 2 any Injury or other 2008.		> Mortan Man	ila	1		ern Ave	-			гп
,35		Г	23a. Part1. Enter the discase, or complications shock, or heart failure. List only one cause	at caused the d						2,23,	Approximate Interval Between
). 	Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	ue to (or as a consue to (or as a cons	sequence of):	si S					Onset and Death
09/00,	ficate be executed physician and is the burial-transit	edical Examiner	that initiated events	ue to (or as a cons	sequence of):						
O. BOX	res that the death certifigned by the attending be detached for use a	Physician/Me	in the past 12 months?	es, outcome of pre Live birth 2 Pregnant at time of Unknown	etal death 3	Ectopic pregnancy Other (specify)	′		23d.	Date of delive Month	ry Day Year
cords, P	law requires that the as been signed by th 2 should be detache	ρ	Par II. Other significant conditions contributions Reguined Dennus	g to death but not	resulting in the u	nderlying cause giv	ren in Part I.	23e. Did to			e cause of death? ably 4 \textcal{D}Unknown
ů L	The law re ete has bee page 2 sho	Completed	Hepotitis C					24a. Was a autops perform	y	death?	esy findings available a pletion of cause of
<u> </u>	clan: ertific	Be	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only on	ie)		
6	Physic this c	2	1 XYes 2 No Hospital		₽ Proutpatien		4 L Nursing no	ome 5 Reside)
	nding lath. r: After e funer	ation	27. Manner of Death 28a. Natural 5 Pending 2 Accident investigation	Date of Injury (Month, Day Year	28b. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe ho	ow injury oc	curred	
DIVISION	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has a completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e.	Place of Injury - A building, etc. (Spe	t home, farm, str ecify)	eet, factory, office		28f. Location (Si City or Town	treet and No n, State)	um <i>b</i> er or Rural	Route Number,
	e Hosp 24 hou Fune letely fit	edical	29a. Certifier (Check only one) (Check only one)	To the best of my to the basis of examination of the basis of examination of the basis of the ba	knowledge, death nination and/or in	n occurred at the tirvestigation, in my o	ne, date and place, pinion, death occur	and due to the cred at the time, d	ause(s) and ate and pla	d manner as sta ce, and due to	ated. the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	N		29c. Licens		2	29d. Date signed (Month, Day, Year)		
)			> Worken)		C	CME		JULY	25, 2	2005
			30. Name and address of person who complete	d cause of death (Item 23 <i>a</i>) (Type,		enn Stree	et Balt:	imore.	, Maryl	and 21201
	Sta	ate	31. Date filed (Month, Day, Year)	32. Paistrar's Si	gnature	Could !					

David Howard UNK 05-05056 05-05056 RPD

-05	056)	For	State of Ma	•	•			nd Mental H	ygiene	= -9.5.	
PD			1 - State Registrar			Certific	cate of L	Death	2. Date of D	Reg. No	2005	25226
3	Physici	an	Decedent's Name (First, Middle, Last David Raynard H	•					July 2		2005 Year	0040 A M
	/Medic Examir		4a. Facility Name (If not institution, give University Hospit	street and number)			City, Town, or altimor				c. County of Death	0040 11
	Funeral Director		5. Social Security Number 6. S 213-47-9214	ex 7. Age LXM 2□F	(In yrs. last bir		Inder 1 Year nths Days	If Under 24 Hours	# Hrs. 8. Date of 8 (Month, Date of 11 – 2	irth Day, Year) 2-85	9. Birthp Court MD	lace (State or Foreign try)
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Locatio	n				1	0d. Inside City Limits
	Maryla 1 sho	to	MD Baltimo	re	Parkv							1 □Yes 2X No
	or 28e	irec	10e. Street and Number	,10	rarkv		of, Zip Code			10g. Ci	tizen of What Cour	itry?
	23a c	a D	103 Ashlar Hill	Cţ.			21234			US		
21215-0036	iges 1 and 2 should be filed within 72 hours after deeth with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or itema 23a or 28e-f show or other traumatic event, the Medical Exat	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 I If Yes, Give Year or Dates:			Decedent of His s, specify Cubar res 2XNo	spanic Origin, Mexican, Specify:	n? (Specify Yes or N Puerto Rican, etc.)	lo-	14. Race - Americ Black, White, SpecifyBlac	etc.
2-0	72 ho	eted	15. Decedent's Ed (Specify only highest gra		16a.	Decedent's	of work done d	tion uring most o	of working	16b. K	Kind of Business/Ind	dustry
121	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5-		uden:				Hic	gh Schoo	\1
d 2	filed Hygid other	Be Co	17. Father's Name (First, Middle, Last)		50	uuen		18. Mother's	s Name (First, Middl)1
Maryland	2 should be filed and Mental Hygi is marked other aumatic event.	To B	James P. Howard	l				Myrna	a L.Greg	g		
ary	2 should and Men ie marke aumatic		19a. Informant's Name/Relationship (Type, Print)	19b	. Mailing Ad	Idress (Street a	nd Number	or Rural Route Num	ber, City	or Town, State, Zip	Code)
	1 and 2 Health tem 27		Myrna L. Gregg	(mother)	10 20b. Place of			alto.	MD 212	7		Chat
Baltimore,	Pages 1 nent of H nnt: If ite iry or ot		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification)		Sacre	ry, cremator	y or other place		-3-05		ocation - City or To	
3alti	permit. Pages Department of importent: If i any injury or one		21. Signature of Funer 15 rvice Licer	See / /	43	22. Na	me and Addres	s of Facility	Wesley C	havi	s Jr. F	Ή.
	0 0 5 € 0		220 Part 1 Enter the disease of orm	plications that caused	doub Do				Ave. Bal		MD 2123	Approximate
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or come shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	aDue to (or as a	consequence	gun.	shot	Wou	445			Interval Between Onset and Death
3760,	eath certificate be executed ettending physicien and for use as the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	c.	consequence							
P.O. Box 68	Physicien: The law requires that the death certificate be executed this certificate hes been signed by the ettending physicien and rail director, page 2 should be detached for use as the bunat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 24 ☐ Pregnant at 19 ☐ Unknown	2 🗌 Fetal death		opic pregnancy er (specify)				23d. Date of delive Month	ary Day Year
	ires that signed t	ρ	Part II. Other significant conditions of	ontributing to death bu	t not resulting in	n the under	ying cause give	n in Part I.			use contribute to the	ne cause of death?
Records,	aw requir s been s 2 should	Completed							24a. Wa	s an	24b. Were auto	psy findings available
Ä	Physicien: The lav this certificete hes al director, page 2 a	Com							per Yes	opsy formed? 2 □ No	death?	mpletion of cause of 2 No
Vital	cien: ertific ector.	Be	25. Was case referred to medical examiner?				la		of Death (Check only	опе)		
of	Physic this c	5	1 Yes 2 No	Hospital: 1 ☐ Inpatier 28a. Date of Injury		utpatient 3			sing Home 5 ☐ Res 28d. Describe			y)
Division	After Fune	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	HUGOT	Year) Fund	Time of Injury	28c. Injury Work	es 2 N	01	ject	shot	
ivis	or Attender de Directorin by the	rtific	3 Suicide 6 Could not b determined	28e. Place of Inju building, etc	ry - At home, fa . (Specify)	arm, street, f	actory, office	4	City or T	own, State	nd Number or Rura	
0	urs ef				Stre	et i	451che +	he cal				etimier, HD
	Hosp 24 ho Fune Fune	Medical		ysicien: To the best on niner: On the basis of and manner state	examination an							
	To the Hospital or Attend within 24 hours effer deeth To the Funerel Director: completely filled in by the	Me	29b. Signature and title of certifier	100 A	9.		29c. License O.C.M				ate signed (Month, y 27, 200	
			30. Name and address of person who	completed cause of de				R ₂ 1+4	more, Mar	vil and	d 21201	
8	Sta Regist	ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	r с тпт у	ocreet,	חמדנו	more, rat	утап	u ZIZUI	
DH	MH 17 Rev 1/2		7000	32. Registra	MARI A	y. 1	back			-		
					OF	RIGINAL	- an entrief					

Funeral Director

	-	
	F	State Registrar
1	17	Rev 1/2001

n	Registrar				Cei	rtificate of D	eath	- 1	Reg. Non	000	0000
n	1. Decedent's Nam	ne (First, Middle,	Last)					2. Date of Dea	ith Day	002	C. Time of Dea
_	Charles	Louis J	Jones					JUNE	19	, 2005	08:35
al - er	4a. Facility Name ('If not institution, g	give street and number)		4b. City, Town, or I	ocation of Death		4c. C	ounty of Death	n
	VA MARYI	LAND HEAD	LTH CARE SY	YSTEM		PERRY PO	TAIC		CEC	CIL	
	5. Social Security I	Number 6		ge (In yrs. last	birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	Year)	9. Birth	nplace (State or Fo
	220-36-0	353	1 M 2□ F	64	Yrs.	Months Days	TIOUTS IVIII.	FEB. 1			Maryland
	Usual Residence of	10b. County		10c. City, To		action					10d. Inside City Li
_	10a. State		. 77								1 ☐ Yes 2 ₹
Director	MD		Arundel	MILLI	rersv	rille				(110) . 0	
	10e. Street and Nu					10f. Zip Code			10g. Citize	on of What Co	untry?
ī		eterans I	Highway #79		100	21108			14	USA	in a ladica
Funeral	11. Marital Status		12. Was Deceden Armed Forces	?	1 1	Was Decedent of His If Yes, specify Cuban	panic Origin? (Sp i, Mexican, Puerto	Rican, etc.)	1	 Race - Amer Black, White 	
by F		ried 2 Married 4 Divorced	If Yes, Give 7	ir For	ce	1□Yes 2∏ No	Specify:		s	Specify: wh	ite
	3 11100460	15. Decedent's				dent's Usual Occupat	tion		16h Kind	d of Business/l	Industry
Completed		cify only highest	grade completed)		(Give	kind of work done du DO NOT use retired)	uring most of work	ring			el County
ш	Elementary/Sec	ondary (0-12)	College (1-4or			pard of Ed					ducation
_	17. Father's Name	(First, Middle, La	ast)		011 100		18. Mother's Nam	e (First, Middle,			-
Be		Unknow					_	nown		,	
မ	10a Informantia N	Vame/Relationship		Π,	10b Mailie	ng Address (Street ar			r City or	Tour State 7	in Code)
											.p code)
	20a. Method of Dis	orris - 1	rriena			Vatts Aven		Date	2114	ation - City or 1	Town State
		•	B □Removal from State	6		sition (Name of matory or other place					
	° 4 □ Donation	5 Other (Spe	ecify)	Crow		lle Vet. C		4/2005	Crow	msvill	e, MD
	21. Signature of F	uneral Service Li	censee		Ga.	2. Name and Address L. Kau	s of Facility E ma n Fune	eral Hon	ne @ M	eadowri	idae MP, Ir
		St. F	tucm	in		50 Washing					21075
	23a. Part1. Enter shock, or he	the isease, or co art failure. List or	omplications that cause nly one cause on each	ed the death. Dine.	Do not ent	ter the mode of dying	, such as cardiac	or respiratory a	rest,		Approximate Interval Between
	Immediate Cause	(Final	A OTTOR A	MANAMAN	TAT	TMEADOWTON	T.				Onset and Deat
	resulting in death		Due to (or a	s a consequen	ce of):	LIVEANCLICE					DIVIGIONIA
	disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): ATHEROSCLEROTIC CARDIOVASCULAR DISEASE										
	Sequentially list o	anditions	D. ATHEROS	SCLEROT	IC C	ARDIOVASCU	JLAR DISE	EASE			UNKNOWN
ner	Sequentially list c if any, leading to cause. Enter Und	onditions, mmediate Jerlying		SCLEROT s a consequen		ARDIOVASCU	JLAR DISE	EASE			UNKNOWN
aminer	Cause (Disease of that initiated even	lerlying or injury ts	Due to (or a	s a consequen	ice of):	ARDIOVASCU	JLAR DISE	EASE			UNKNOWN
Examiner	Cause (Disease of	lerlying or injury ts	Due to (or a	s a consequen	ice of):	ARDIOVA SC U	JLAR DISE	EASE			
ā	Cause (Disease of that initiated even	lerlying or injury ts	Due to (or a	s a consequen	ice of):	ARDIOVASCU	JLAR DISE	EASE			
ā	cause. Enter Unc Cause (Disease of that initiated even resulting in death)	lerlying or injury ts	Due to (or a HYPERL) Due to (or a	s a consequen	ice of):	ARDIOVASC	JLAR DISE	EASE			
ā	cause. Enter Und Cause (Disease o that initiated even resulting in death) IF FEMALE: 23b. Was decede	lertying rinjury ts Last	c. HYPERL Due to (or a d. 23c. If yes, outcome	s a consequent IPIDEMI s a consequent a consequent a of pregnancy	A ce of):		JLAR DISE	CASE	23	3d. Date of deli	UNKNOWN
ā	Cause. Enter Und Cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1. 1 □ Yes 2	intying rinjury ts Last Int pregnant 2 months?	Due to (or a d. HYPERL.) Due to (or a d. 23c. If yes, outcome 1 Live birth 4 Pregnant.	s a consequent IPIDEMI s a consequent	A ce of):	ARDIOVASCU	JLAR DISE	EASE	23	3d. Date of deli Month	UNKNOWN
ā	cause. Enter Und Cause (Disease o that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1	intying rinjury ts Last Int pregnant 2 months?	Due to (or a c. HYPERL) Due to (or a d. 23c. If yes, outcom	s a consequent IPIDEMI s a consequent a consequent e of pregnancy 2 Fetal de	A ce of):	□Ectopic pregnancy	JLAR DISE			Month	UNKNOWN very Day Year
Physician/Medical	Cause. Enter Und Cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was deceded in the past 1 1 Yes 2 9 Unknow Part II. Other sign	nt pregnant 2 months? No n	c. HYPERL. Due to (or a d. 23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	s a consequent is a consequent	A coe of): A coe of): A ath 3[h 5[]	□Ectopic pregnancy □ Other (specify)		23e. Did t	obacco us	Month e contribute to	UNKNOWN very Day Year the cause of death
by Physician/Medical	Cause. Enter Und Cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was deceded in the past 1 1 Yes 2 9 Unknow Part II. Other sign	nt pregnant 2 months? No n	c. HYPERL Due to (or a d. 23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	s a consequent is a consequent	A coe of): A coe of): A ath 3[h 5[]	□Ectopic pregnancy □ Other (specify)		23e. Did t	obacco us	Month e contribute to	UNKNOWN very Day Year
by Physician/Medical	Cause. Enter Und Cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was deceded in the past 1 1 Yes 2 9 Unknow Part II. Other sign	nt pregnant 2 months? No n	c. HYPERL. Due to (or a d. 23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	s a consequent is a consequent	A coe of): A coe of): A ath 3[h 5[]	□Ectopic pregnancy □ Other (specify)		23e. Did t	obacco us /es 2 🗆	Month e contribute to	UNKNOWN Ivery Day Year the cause of death babbly 4 Munkr topsy findings avai
by Physician/Medical	Cause. Enter Und Cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was deceded in the past 1 1 Yes 2 9 Unknow Part II. Other sign	nt pregnant 2 months? No n	c. HYPERL. Due to (or a d. 23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	s a consequent is a consequent	A coe of): A coe of): A ath 3[h 5[]	□Ectopic pregnancy □ Other (specify)		23e. Did t	obacco us /es 2 □ an isy rmed?	Month e contribute to No 3 Pro 24b. Were au prior to odeath?	UNKNOWN Ivery Day Year the cause of death babbly 4 Munkr topsy findings avaicempletion of cause
Completed by Physician/Medical	cause. Enter Und Cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1 1 Yes 2 9 Unknow Part II. Other sign	nt pregnant 2 months?	c. HYPERL. Due to (or a d. 23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	s a consequent is a consequent	A coe of): A coe of): A ath 3[h 5[]	□Ectopic pregnancy □ Other (specify)	n in Part I.	23e. Did t 1 24a. Was autoj perfo 1 Yes	obacco us /es 2 □ an an asy rmed? 2 No	Month e contribute to No 3 Pro 24b. Were au prior to odeath?	UNKNOWN Ivery Day Year the cause of death babbly 4 Munkr topsy findings avai
Be Completed by Physician/Medical	Cause. Enter Unc Cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1 1 Yes 2 9 Unknow Part II. Other sign CHRONT	nt pregnant 2 months? No n ifficant condition C OBSTRU	Due to (or a c. HYPERL.) Due to (or a d. 23c. If yes, outcome 1 Live birth 4 Pregnant 9 Unknown 1 CTIVE LUNG	s a consequent in a consequent	A ice of): A ice of): / ath 3[h 5[mg in the u	□Ectopic pregnancy □ Other (specify) inderlying cause give	n in Part I. 26. Place of Deal	23e. Did to 1	obacco us /es 2 an an an asy rmed? 2 \notine)	Month e contribute to No 3 Pro 24b. Were au prior to codeath? 1 Yes	UNKNOWN Ivery Day Year the cause of death babbly 4 Munkr topsy findings avaicemplation of cause 2 No
: To Be Completed by Physician/Medical	Cause. Enter Und Cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1 1 Yes 2 9 Unknow Part II. Other sign CHRONI 25. Was case refe	nt pregnant 2 months? No C OBSTRU	Due to (or a c. HYPERL Due to (or a d. 23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown as contributing to death ICTIVE LUNG Hospital: 1 Vinpal 28a. Date of in	s a consequent iPIDEMI s a consequent e of pregnancy 2 Fetal de at time of death but not resultin DISEAS	A ice of): A ice of): / ath 3[h 5[mg in the u	□Ectopic pregnancy □ Other (specify) Inderlying cause give out 3□ DOA Other	n in Part I. 26. Place of Deal 1. 4 \(\) Nursing Hoat	23e. Did to 1	obacco us /es 2 an ssy rmed? 2 No ne)	Month e contribute to INo 3 pro 24b. Were au prior to c death? 1 yes	UNKNOWN Ivery Day Year the cause of death babbly 4 Munkr topsy findings avaicemplation of cause 2 No
: To Be Completed by Physician/Medical	Cause. Enter Und Cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1 1 □ Yes 2 9 □ Unknow Part II. Other sign CHRONI 25. Was case reference examiner? 1 □ Yes 2 27. Manner of Death	int pregnant 2 months? No n ifficant condition C OBSTRU	Due to (or a c. HYPERL. Due to (or a d. 23c. If yes, outcome 1 Live birth 4 Pregnant 9 Unknown as contributing to death ICTIVE LUNG	s a consequent iPIDEMI s a consequent e of pregnancy 2 Fetal de at time of death but not resultin DISEAS	/ A lice of): // A lice of): // ath 3[h 5[mg in the u BE	DEctopic pregnancy Other (specify) Inderlying cause give	n in Part I. 26. Place of Deat 7. 4 \(\to \) Nursing Ho at 7.	23e. Did t 1 1 24a. Was autor perfo 1 1 Yes th (Check only come 5 Resident)	obacco us /es 2 an ssy rmed? 2 No ne)	Month e contribute to INo 3 pro 24b. Were au prior to c death? 1 yes	UNKNOWN Ivery Day Year the cause of death babbly 4 Munkr topsy findings avaicemplation of cause 2 No
: To Be Completed by Physician/Medical	Cause. Enter Und Cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1 1 Yes 2 9 Unknow Part II. Other sign CHRONI 25. Was case refe examiner? 1 Yes 2 27. Manner of Dea	int pregnant 2 months? No n arred to medical XNo ath S Pending investiga 6 Could no	Due to (or a c. HYPERL.) C. HYPERL. Due to (or a d. e. e. e. e. e. e. e. e. e. e. e. e. e.	s a consequent in the consequent in the consequent is a consequent in the consequent	A see of): A see	DEctopic pregnancy Other (specify) Inderlying cause give out 3 DOA Other of 28c. Injury Work M 1 Y	n in Part I. 26. Place of Deal 1. 4 \(\) Nursing Hoat	23e. Did t 1	obacco us /es 2 an sisy rmed? 2 No ne) dence 6 now injury	Month e contribute to INo 3 pro 24b. Were au prior to c death? 1 Yes Other (Spec	UNKNOWN Ivery Day Year the cause of death babably 4 Munkr topsy findings avaicompletion of cause 2 No
: To Be Completed by Physician/Medical	cause. Enter Und Cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1 1	nt pregnant 2 months? No n Triplery to the served to medical No atth S Pending investiga 6 Could no	Due to (or a c. HYPERL.) Due to (or a d. 23c. If yes, outcome 1 Live birth 4 Pregnant 9 Unknown as contributing to death ICTIVE LUNG Hospital: 1 Vinpal (Month, E. 28a. Date of in (Month, E. 28a. Place of in (Month))	s a consequent in the consequent in the consequent is a consequent in the consequent	A see of): A see	DEctopic pregnancy Other (specify) Inderlying cause give	n in Part I. 26. Place of Deat 7. 4 \(\to \) Nursing Ho at 7.	23e. Did t 1	obacco us Yes 2 an an sy rmed? 2 No ne) dence 6 now injury	Month e contribute to INo 3 pro 24b. Were au prior to c death? 1 Yes Other (Spec	UNKNOWN Ivery Day Year the cause of death babbly 4 Munkr topsy findings avaicemplation of cause 2 No
Certification: To Be Completed by Physician/Medical	cause. Enter Unc Cause (Disease o that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1 1 Yes 2 9 Unknow Part II. Other sign CHRONI 25. Was case refe examiner? 1 Yes 2 27. Manner of Dea 1 Natural 2 Accident 3 Suicide 4 Homicide	nt pregnant 2 months? No n compared to medical XNo ath Some period of the period of	Due to (or a c. HYPERL.) Due to (or a d. 23c. If yes, outcome 1 Live birth 4 Pregnant 9 Unknown as contributing to death ICTIVE LUNG Hospital: 1 Vinpal 28a. Date of in (Month, Date death 28a. Place of it building, of the lead 28a. Place of it building, of the lead 28a. Place of it building, of the lead 28a. Place of it building, of the lead 28a. Place of it building, of the lead 28a. Place of it building, of the lead 28a. Place of it building, of the lead 28a. Place of it building, of the lead 28a. Place of it building, of the lead 28a. Place of it building, of the lead 28a. Place of it building, of the lead 28a. Place of it building, of the lead 28a.	s a consequent in the consequent in the consequent is a consequent in the consequent	/ A lice of): // A lice of): // ath 3[h 5[Ing in the u BE // Outpatier John Time o Injury John St. Time o	DEctopic pregnancy Other (specify) Int 3 DOA Other At 3 DOA of 28c. Injury Work M 1 Y reet, factory, office	n in Part I. 26. Place of Deat r. 4 □ Nursing Ha 2? es 2 □ No	23e. Did t 1 1 24a. Was autor perdo 1 24e. Yes th (Check only of ome 5 Resident 28d. Describe	obacco us /es 2 □ an sy rmed? 2 No ne) dence 6 now injury Street and vn, State)	Month e contribute to INO 3 Pro 24b. Were au prior to c death? 1 Yes Other (Spec occurred	UNKNOWN Ivery Day Year the cause of death babably 4 Munkr topsy findings avaicompletion of cause 2 No
Certification: To Be Completed by Physician/Medical	cause. Enter Unc Cause (Disease o that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1 1	nt pregnant 2 months? I hast Interpregnant 2 months? No n Ifficant condition C OBSTRU And the served to medical No ath S Pending investiga C Could no determin	Due to (or a c. HYPERL.) Due to (or a d. Due	s a consequence of pregnancy 2 Fetal de at time of death but not resultin DISEAS tient 2 ER. jury 28 ay Year) 28 njury - At home atc. (Specify) st of my knowle of examination	A ace of): A ace of): A ace of): A ace of): A ce of	DEctopic pregnancy Other (specify) Inderlying cause give Int 3 DOA Other If 28c. Injury Work M 1 Y reet, factory, office	n in Part I. 26. Place of Deat r. 4 \(\text{Nursing Ho} \) at res 2 \(\text{No} \) e, date and place,	23e. Did t 1 1 24a. Was autor perfo 1 1 Yes th (Check only come 5 Resire 28d. Describe 1 28f. Location (City or Total	an symmed? 2 No ne) dence 6 now injury	Month e contribute to INo 3 pro 24b. Were au prior to c death? 1 yes Other (Spec occurred	UNKNOWN Very Day Year the cause of death babably 4 (Munkr topsy findings ava- completion of cause 2 \(\subseteq \) No Cify) val Route Number, stated.
Certification: To Be Completed by Physician/Medical	cause. Enter Unc Cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1 1	nt pregnant 2 months? No No No	Due to (or a c. HYPERL.) Due to (or a d. 23c. If yes, outcome 1 Live birth 4 Pregnant 9 Unknown 1 S contributing to death 1 CTIVE LUNG 28a. Date of In (Month, E deed 28e. Place of I building, of Physicien: To the best	s a consequence of pregnancy 2 Fetal de at time of death but not resultin DISEAS tient 2 ER. jury 28 ay Year) 28 njury - At home atc. (Specify) st of my knowle of examination	A ace of): A ace of): A ace of): A ace of): A ce of	DEctopic pregnancy Other (specify) Inderlying cause give and 3 DOA Other 28c. Injury Work M 1 Y reet, factory, office th occurred at the tim ivestigation, in my op	n in Part I. 26. Place of Deat 7. 4 Nursing Ho at ? es 2 No e, date and place, inion, death occur	23e. Did t 1 1 24a. Was autor performe 5 Resirence 28d. Describe 28f. Location (City or Tour and due to the reed at the time,	obacco us Yes 2 an ssy rmed? 2 No ne) dence 6 now injury Street and m, State) cause(s) a date and g	Month e contribute to No 3 Pro 24b. Were au prior to c death? 1 Yes Other (Spec occurred	UNKNOWN Ivery Day Year I the cause of death obably 4 Munkr Itopsy findings avail completion of cause 2 No Diffy) Iral Route Number, stated, to the cause(s)
ertification: To Be Completed by Physician/Medical	cause. Enter Unc Cause (Disease o that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1 1	nt pregnant 2 months? No No No	Due to (or a c. HYPERL.) Due to (or a d. Due	s a consequence of pregnancy 2 Fetal de at time of death but not resultin DISEAS tient 2 ER. jury 28 ay Year) 28 njury - At home atc. (Specify) st of my knowle of examination	A ace of): A ace of): A ace of): A ace of): A ce of	DEctopic pregnancy Other (specify) Inderlying cause give Int 3 DOA Other If 28c. Injury Work M 1 Y reet, factory, office	n in Part I. 26. Place of Deat 7. 4 Nursing Ho at ? es 2 No e, date and place, inion, death occur	23e. Did t 1 1 24a. Was autor performe 5 Resirence 28d. Describe 28f. Location (City or Tour and due to the reed at the time,	obacco us Yes 2 an an syy med? 2 No Bence 6 fow injury Street and my, State) cause(s) a date and g 29d. Date	Month e contribute to No 3 Pro 24b. Were au prior to c death? 1 Yes Other (Spec occurred Number or Ru and manner as blace, and due	UNKNOWN Ivery Day Year I the cause of death obably 4 Munkr topsy findings avar completion of cause 2 No Dify) Iral Route Number, stated, to the cause(s)
Certification: To Be Completed by Physician/Medical	cause. Enter Unc Cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1 1	nt pregnant 2 months? No No No	Due to (or a c. HYPERL.) Due to (or a d. Due	s a consequence of pregnancy 2 Fetal de at time of death but not resultin DISEAS tient 2 ER. jury 28 ay Year) 28 njury - At home atc. (Specify) st of my knowle of examination	A ace of): A ace of): A ace of): A ace of): A ce of	DEctopic pregnancy Other (specify) Inderlying cause give and 3 DOA Other 28c. Injury Work M 1 Y reet, factory, office th occurred at the tim ivestigation, in my op	n in Part I. 26. Place of Deat 7. 4 Nursing Ha 12. (es 2 No e, date and place, inion, death occur	23e. Did t 1 1 24a. Was autor performe 5 Resirence 28d. Describe 28f. Location (City or Tour and due to the reed at the time,	obacco us Yes 2 an an syy med? 2 No Bence 6 fow injury Street and my, State) cause(s) a date and g 29d. Date	Month e contribute to No 3 Pro 24b. Were au prior to c death? 1 Yes Other (Spec occurred Number or Ru and manner as blace, and due	UNKNOWN Ivery Day Year I the cause of death obably 4 Munkr Itopsy findings avail completion of cause 2 No Diffy) Iral Route Number, stated, to the cause(s)
Certification: To Be Completed by Physician/Medical	cause. Enter Unc Cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was deceded in the past 1 1	nt pregnant 2 months? No no no no no no no no no no no no no no	Due to (or a c. HYPERL.) Due to (or a d. 23c. If yes, outcome 1 Live birth 4 Pregnant 9 Unknown 1 Scontributing to death 1 CTIVE LUNG 28a. Date of In (Month, Date 28e. Place of It building, of the physicien: To the best sand manner such that completed cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the cause of the complete cause of the complete cause of the complete cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of	s a consequent in the programme of pregnancy 2 Fetal de at time of death but not resulting DISEAS titlent 2 ER pury lay Year) 28 anjury - At home of examination stated.	A lice of): A lic	DEctopic pregnancy Other (specify) Int 3 DOA Other 28c. Injury Work M 1 Y reet, factory, office th occurred at the timestigation, in my open contents 29c. License D24648	26. Place of Deat C 4 Nursing Ho at ? es 2 No e, date and place, inion, death occur number	23e. Did t 1 1 24a. Was autor performence to the Check only of the Check only of the Come 5 Resired 28d. Describe 28f. Location (City or Tout and due to the red at the time,	obacco us Yes 2 an sy rmed? 2 No dence 6 now injury Street and one, State) cause(s) a date and of 29d. Date	Month e contribute to INO 3 Pro 24b. Were au prior to c death? 1 Yes Other (Spec occurred Number or Ru and manner as place, and due signed (Month	UNKNOWN Very Day Year the cause of death obably 4 Munkr topsy findings avail completion of cause 2 No Polity) Veral Route Number, to the cause(s) The Day, Year) 2 O 5
Certification: To Be Completed by Physician/Medical	cause. Enter Unc Cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was deceded in the past 1 1	nt pregnant 2 months? No no no no no no no no no no no no no no	Due to (or a c. HYPERL.) Due to (or a d. Due	s a consequent in the programme of pregnancy 2 Fetal de at time of death but not resulting DISEAS titlent 2 ER pury lay Year) 28 anjury - At home of examination stated.	A lice of): A lic	DEctopic pregnancy Other (specify) Int 3 DOA Other 28c. Injury Work M 1 Y reet, factory, office th occurred at the timestigation, in my open contents 29c. License D24648	26. Place of Deat C 4 Nursing Ho at ? es 2 No e, date and place, inion, death occur number	23e. Did t 1 1 24a. Was autor performence to the Check only of the Check only of the Come 5 Resired 28d. Describe 28f. Location (City or Tout and due to the red at the time,	obacco us Yes 2 an sy rmed? 2 No dence 6 now injury Street and one, State) cause(s) a date and of 29d. Date	Month e contribute to INO 3 Pro 24b. Were au prior to c death? 1 Yes Other (Spec occurred Number or Ru and manner as place, and due signed (Month	UNKNOWN Very Day Year the cause of death obably 4 Munkr topsy findings avail completion of cause 2 No Polity) Veral Route Number, to the cause(s) The Day, Year) 2 O 5

ORIGINAL

CPM 05-05136 William

iar	n Jacks	on	amend item/196,	PETTH, G846, 8/3/0 State of Maryland /	ck indelible ink	. Ensure A	II Copies A	re Legible.	
			1 - State Registrar	State of Maryland	Certificate of			g. No. 7 A A C	05000
1	Physic	an	Decedent's Name (First, Middle, Last,	. 1			2. Date of Death	2003	8. Time of Death
	/Medi Examir	cal	4a. Facility Name (If not institution, give	HENRY street and number)	JACKS	or Location of Death	July	30, 2005	15:11 M
*	Examili	er 。。	2416 Chetwood Cir	cle	Timon	ium		Baltim	
	Funeral Director		5. Social Security Number 6. Sec. 12	x 7. Age (In yrs. last b	oirthday) If Under 1 Year Yrs. Months Days		8. Date of Birth (Month, Day,	Year) 9. Birth	pplace (State or Foreign intry) RGINIA
	D D		Usual Residence of Decedent 10a. State 10b. County	10c City To	wn or Location		001.17		10d. Inside City Limits
	hours after death with the Maryland turst', or Iteme 23a or 28a-f ahow al Exaction from the profitted at	tor	n	TIMORE	PAR	VVIILE	eda.		1 ☐ Yes 2 ☒No
	or 28s	Director	10e. Street and Number	0 -	10f. Zip Code	2 . 6 .	10	g. Citizen ol What Cou	untry?
	ne 23a	Funeral	1 TERRON 11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of	ス/ 23 4 Hispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Amer	ican Indian.
98	or Iter	y Fun	1 Never Married 2 Married	Armed Forces? 1 ★ Yes 2 □ No If Yes, Give	13. Was Decedent of If Yes, specify Cub		Rican, etc.)	Black, White	
21215-0036	J within 72 hours after death with the Marylan jiene. r than "natural", or Iteme 23a or 28a-f ahow The Wedical Examinat must be excitted at	ted by	3 Widowed 4 Divorced 15. Decedent's Edu	Year or Dates:	a. Decedent's Usual Occur	pation	1	6b. Kind of Business/li	ACK
1215	within 73 ene. than "n	Completed	(Specify only highest grad	(e completed) College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	during most of work id)	ring	. / -	,
d 2	Thy H	0	17. Father's Name (First, Middle, Last)		DISAR	18. Mother's Nam	e (First, Middle, M.	A aiden Sumame)	
Maryland		To B	WILLIAM	H. LOGA	TN	GRAC	E	JACK	SON
Mar	d2 s		19a. Informant's Name/Relationship (Ty DEBORAH TACKS	rpe, Print) 19	b. Mailing Address (Street	and Number or Rui	Parkyi	City or Town, State, Zi	p Code)
ore,	1 ar Hea Hea Hea the		20a. Method of Disposition 1 Surial 2 Cremation 3 F	i aamat	of Disposition (Name of ery, crematory or other pla	(ce)	Date 2	Oc. Location - City or T	own, State
Baltimore,	Pagent nt: h		4 Denation 5 Other (Specify)	TR//	NITY CEME	TERY 08-0	14-05 X	3ALTIMOK	E MA. AL HOME
Bal	permit. Departm Imports any inju		21. Sign ture of Fune of Favice Licens	1	22 Name and Addre	ess of Facility		R, FUNER BALTO, M	
E.			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	lications that caused the death. Do	not enter the mode of dy	ng, such as cardiac			Approximate Interval Between
in the contract of the contrac	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a LUNSHOT SNOVA		MEST AND) ARM		Onset and Death
	Examiner		Sequentially list conditions.	Due to (or as a consequence	e ot):				
	pet list	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a sunsequence	a off.				
oʻ	te be executed ysician and e burial-transit		that initiated events resulting in death) Last	Due to (or as a consequence	e of):				
09289	physicis	dicai		d					
Вох 6	death certificate e attending phys of for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	ab 205-t			23d. Date of deliv	/ery
-	0 0	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 2□Fetal deat 4□Pregnant at time of death 9□Unknown	th 3 □Ectopic pregnanc 5 □ Other (specify) _	·y		Month	Day Year
P.O	law requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significant conditions con	ntributing to death but not resulting	in the underlying cause gr	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
of Vital Records,	w require been sig should b						1 ☐ Yes	2 Ž No 3 ☐ Pro	bably 4 Unknown
Rec	0 - 0	Completed					24a. Was an autopsy perform	prior to co	opsy findings available ompletion of cause of
ital		Be Co	25. Was case referred to medical			26. Place of Deal		□ No 178 Yes	2□ No
of <	Phys this al dii	ဥ	examiner? 1 X Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ ER/C	Julpatient 3 DOA	her: 4 Nursing Ho		nce 6 Other (Speci	' ^(y) SCENE
lon	ding h. After fune	ation	1 □ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	Time of lnjury Wo	rk?]Yes 2∭No	28d. Describe how S√B TECT	- 1 44	lot
Division	or Attendativiter death	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ★ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)			City or Town,		
	e Hospital or Atten 24 hours after deat Funeral Director: etely filled in by the		29a. Certifier 1 Certifying Phy	STREET sician: To the best of my knowledge	ge, death occurred at the ti	me, date and place	and due to the car	isa(s) and manner as	TIMONIUM, MD
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	one) 2(1) Medical Exami	iner: On the basis of examination a and manner stated.	and/or investigation, in my	opinion, death occur	red at the time, dat	e and place, and due	to the cause(s)
)	Neith Co.	2	29b. Signature and title of certifier	k.	29c. Licen:			d. Date signed (Month,	
/	11		30. Name and address of person who co	ompleted cause of death (Item 23a		C.M.E.		July 31, 20	105
- (MIO, HD	111 Penn St	reet, Bal	timore, M	Maryland 21	.201
	Sta Regist		AUG 0 3 2	32. Registrar's Signature	Sperke				
DH	MH 17 Rev 1/2	001							

			For State	State of Maryl		artment of Hertificate of D				
	DI -:-:		Registrar 1. Decedent's Name (First, Middle,			incate of L	Jean	2. Date of Death	n Day Year	3 Time of Death
	Physicia /Medic	al	FRANCES. 4a. Facility Name (If not institution, g	M JEW	ELL	4b. City, Town, or	Location of Death	AUGUST	4c. County of Deat	5 0:45AM
	Examin	er	14 AR 130/R	HOSPITAL			IMORE		N/A	
	Funeral Director		220-01-6987	. Sex 7. Age (In 1	yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) Co	hplace (State or Foreign untry) MD
	yland now	1	Usual Residence of Decedent 10a. State 10b. County		. City, Town or Lo		7.1.1			10d. Inside City Limits
	ne Mar Ba-f sl	Director	MD	N/A			Baltimore		0g. Citizen of What Co	1X⊒¥es 2 □ No
	3a or 2	i Dir	10e. Street and Number 1408 Hull	Street		10f. Zip Code	21230	"		SA
980	I within 72 hours after death with the Maryland liene. Then "naturel", or Items 23a or 28a-f show Ite Medical Examinat must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marrier 3 XWidowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 1 Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
21215-0036	within iene. r then "	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done d DO NOT use retired, HOMEMa.ke	luring most of work)	king	16b. Kind of Business/ Own Ho	•
land 2	be filed ital Hyg id othe event,	To Be C	17. Father's Name (First, Middle, La Joseph Wojc				18. Mother's Nam Stella	e (First, Middle, M Krupin		
Maryland	12 sh hand 7 is m traum		19a. Informant's Name/Relationshi						City or Town, State, 2 MD 21230	Zip Code)
Baltimore,	S to L		20a. Method of Disposition 1XX urial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	□Removal from State	oly Cros	natory or other place SS Cem. 7			20c. Location - City or Balto., M.	
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Li	Victor P.	Doda,Jr ²	2. Name and Addres Charles 1501 E.	L. Steve	ens Funer enue, Bal	al Home, I timore MD	nc 21230
	7		23a. Part1. Enter the disease, or c shock, or heart failure. List of	omplications that caused the hly one cause on each line.	death. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a HEM	ORRHA	GIC	SHOCK			One Hour.
	Examiner		Sequentially list dandfrons	6. CONGE	STLVE	HEART	FAI	LURE		5 years.
	uted d ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cor						10 years.
8760,	ate be executed hysician and the burial-transit	dicai Exa	resulting in death) Last	Due to (or as a cor	rsequence of): ERTEA	SION				
O. Box 6	ath certific attending p	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pr 1 Live birth 2 Li	Fetal death 3	□Ectopic pregnancy □ Other (specify)	-		23d. Date of del Month	ivery Day Year
9	juires that the de n signed by the a lid be detached t		Part II. Other significant condition	s contributing to death but no	t resulting in the u	inderlying cause give	en in Part I.		paccourse contribute to	the cause of death?
of Vital Records,		Completed by						24a. Was a autops perform	med? prior to death?	utopsy findings available completion of cause of 2 No
Vita	Physicien: The this certificate har all director, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 DER/Dutpatie	nt 3 DOA Othe	ar	th (Check only on	e) ence 6⊡Other <i>(Spe</i>	cify)
on of	ding Phys h. After this funeral di	tion; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time o	of 28c. Injury Work	/ at		ow injury occurred	y)
Division	il or Attending after death. Director: After d in by the fune	Certification:	3 Suicide 6 Could not determine	ot be	At home, farm, st pecify)	reet, factory, office		28f. Location (St City or Town	treet and Number or R n, State)	ural Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best of my xaminer: On the basis of exa and manner stated.	y knowledge, deat mination and/or in	th occurred at the time	ne, date and place pinion, death occu	, and due to the carred at the time, d	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
	To th within To th	Me	29b. Signature and title of confife	inico	M.D	29c. Licenso	9 number 58 795		9d. Date signed (Mont	
1	3/		30. Name and address of person w	ho letted cause of death	(Item 23a) (Type	Print)				
	Sta	ate	31. Date filed (Month, Day, Year)	3 2005 32. Registrar's 5	Signature.	THE HAVE	WER ST	KEET, 13	ALTIMORE,	MUXIXAS
	Regist	rar	AUG 0	2 7003						

			For State Registrar	State of	Marylar	-	artment of H				giene Reg. No. 2 N	05	25	220
			1. Decedent's Name (First, Middle, La	ast)						2. Date of Dea	ath Day	Year	3. Time of	Đoàn U
	Physici /Medic		Beatrice R. K	endall					J	uly 30	0, Day 200	5	6:50	P₩
	Examin		4a. Facility Name (If not institution, gi		nber)		4b. City, Town, or Balti		of Death		4c. County			
			3811 Bowers A		7 4 //	In a h h hab do a	If Under 1 Year	If Under	24 Hrs. I	0. Data of Pio			1 (01-1	. Carrier
	Funeral			Sex 1 □ M 2√1	7. Age (In yrs.	Yrs.	Months Days	Hours	Min.	8. Date of Birt (Month, Day July	4, 191	9. Birting Cow M.A	olace (State o ntry) rylan	_
	Director		Usual Residence of Decedent		93		l			Dury	±, 151	- 110	T y Lan	
	yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	imore					1	10d. Inside Ci	
	e Mar	ctor	Maryland N/	Α		ратс	THOLE						1 🔀 Yes	2 🗆 No
	ith the	Director	10e. Street and Number				10f. Zip Code	7			10g. Citizen of V	Vhat Cour	ntry?	
	ath w		3811 Bowers Av			10 10	2120		-:-2 (0	-#Van an Na	USA	a Amari	can Indian,	
	ter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Dece Armed Fo	rces?	7.5.	Was Decedent of Hi If Yes, specify Cuba	ispanic On in, Mexicar	n, Puerto F	Rican, etc.)	Blac	k, White,	etc.	
336	urs af	by F	Widowed 4 □ Divorced	If Yes, Giv Year or Da	Θ		1 ☐ Yes 2X No	Specity:			Specify	, Bla	ick	
Š	i within 72 hours after death with the Maryland liene. I than "natural", or Items 23a or 28a-f show The Medical Examil ar must be Lodiffied at	ted	15. Decedent's 8			16a. Dece	dent's Usual Occupa	ation	t of workin		16b. Kind of Bu	ısiness/In	dustry	
21		Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)	1	kind of work done of DO NOT use retired		t or working		Privat	o Tr	ductr	~ \$ 7
21		S	8th grade	A1		Car	e Provi		ada Nama		Maiden Suman		Idusti	- У
and	Q 2 D	Be	17. Father's Name (First, Middle, Las Joseph Jones	1)				Clar	a Tu	irner	Maider Suman	10)		
Ž	should be that and Mental is marked oumatic even	2	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street a	and Numbe	er or Rural	Route Numbe	r. City or Town.	State. Zic	CodeD 1	207
≅	d 2 th a 7 Is		Rita Hamlin/ Da				Bowers							.07
ē,	ss 1 an of Heal of Heal of Heal of Heal		20a. Method of Disposition		20b.	—I Place of Dispo cemetery, crei	esition (Name of matory or other place	(a)	8/8	0 5	20c. Location -	-		
Ë	Pages nent of P ant; If Ite ury or of		1 Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spec				Forest		: · / Čé	em.	Owings	Mil	lls, N	1d
Baltimore, Maryland 21215-0036	permit. Page Department of Important; If any Injury or 2008.		21. Signature of Funeral Service Lice	ensee		5 2 5 2	2. Name and Addres 240 Reis	ss of Facilit Sters	ty Ch stown	natman n Rd B	-Harri altimo	s Fu re,N	ineral 1d 212	Hom 215
			23a. Parri. Enter the disease, or cor shock, or heart failure. List only	nplications that c	aused the dea ach line.	th. Do not ent	er the mode of dyin	ıg, such as	cardiac or	respiratory ar	rest,		Approximate Interval Bet	ween
	Physician		Immediate Cause (Final disease or condition	. A	1 - /	ine's	Disen	se					5 Ye	n/S
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):							9	
	Laminer	_	Sequentially list conditions,	b. — Free to f	ur as a curise	mente di								
4	ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	540101	57 45 4 557155	4001100 017.								
6	arecu n and al-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):						-		
8760,	The law requires that the death certificate be executed the same been signed by the attending physician and tage 2 should be detached for use as the burial-transit			d										
9	tificat ng ph) as th	Physician/Medical	18.551111.5				0.00							
Вох	eath certific attending p for use as 1	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out 1□Live b	come of pregnirth 2 Fet		Ectopic pregnancy	,			23d. Da	e of delive	,	ear/
	e dea the att	SICI	in the past 12 months? 1 □ Yes 2 ♣No 9 □ Unknown	4∐Pregn 9∐Unkno	ant at time of own	death 5	Other (specify)				WIO	17611	Day	Cai
P.0	that the de ed by the detached		Part II. Other significant conditions	contributing to de	eath but not re-	sulting in the u	nderlying cause give	en in Part I		23a. Did to	bacco use cont	ribute to t	he cause of d	eath?
Vital Records,	signe d be	1 by				g	,g g			101	′es 2. No	3 🗆 Prot	oabiy 4 □t	Jnknown
Sor	w requir	ete	O. h.	tes me	111/45					24a. Was	an 24b. V	Nere auto	psy findings	available
Re	The fav ate has page 2	Completed	DININ							autop	med?	prior to co death?	impletion of c	ause of
tai		e C	25. Was case referred to medical					26. Place	of Death	(Check only o		I ☐ Yes	2 140	
>	Physician: this certific ral director,	0 8	examiner? 1 ☐ Yes 2,—√o	Hospital:	npatient 2] ER/Outpatie	nt 3 DOA Oth				dence 6 Oth	er (Specil	fy)	
J of	fing Phy I. After thi funeral	E I	27. Manner of Death	28a. Date of	of Injury	28b. Time o		y at			ow injury occur			
jo	Attending r death. ector: After by the funer	atlc	2 ☐ Accident investigate	on				Yes 2□						
Division	or Attend after death Director:	Certification;	3 Suicide 6 Could not determine	d 200. Flace	of Injury - At h	nome, farm, st ify)	reet, factory, office		2	8f. Location (5 City or Tox	Street and Numb vn, State)	er or Run	al Route Num	ber,
Ω	oltal o urs at eral D						5							
	To the Hospital or within 24 hours after To the Funeral Dirt completely filled in I	edical		ıminer: On the ba			h occurred at the tin vestigation, in my o)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	٥			29c. Licens			1	29d. Date signe	•		
)	^) CAL		MN		0	4315	7		August	2.3	, 2009	
	14		30. Name and address of person who Stude 31. Date filed (Month, Day, Year) AUG 0.3	completed caus	e of death (Ite	m 23a) (Type,	Print)	20 1	1 4	135	Kilho.	201	717	0.12
			31. Date filed (Month, Day, Year)	120	egistrar's Sign	ature 6	frene 17	4 /6	1	, , ,	139110	7-10)	(/)	8
	Sta Registi		ALIC A O	2005	gioriui s oigii	H. A	carle							
			HUU U A	200J 47	CASE A Company	- 17	I I							

Lumpkin, Donald

				Please	Type or Pri	nt in Bla	ack Ind	delible Ink	. Ensure	All Copies	s Are	Legible.	
			1 - For State Registrar		State of M	laryland	-		Health and	Mental Hy	/giene	0.000	
			Registrar 1. Decedent's Name	e (First Middle 1	ast)		Cer	tificate of	Death	2. Date of D	Rag. No	2005	25231
ı	Physic		Donald	Elliott	Lumpkin					Month	Day	Year	3. Time of Death
	/Medi Examii				ve street and number,)		4b. City, Town, o	or Location of Deat	th	4c.	County of De	
			Upper Ch	esapeake Ma	dical Center	2		Harford	County			Harfor	
	Funeral		5. Social Security N			ge (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		rth av. Year)	(rthplace (State or Foreign ountry)
	Director		219 40 3511 Usual Residence of		X. 23. 6	52	Yrs.			December	30 1	942 Bal	timore, Maryland
	yland how		10a. State	10b. County		10c. City, T	own or Lo	cation					10d. Inside City Limits
	e Ma	Director	Maryland	Baltimore		White	e Mars	h					1 ☐ Yes 2 No
	with th		10e. Street and Nur		,			10f. Zip Code			10g. Citi	zen of What C	country?
	eath i	erai	6041 Lorele	ey Beach Ro	12. Was Decedent	- Ever in II C	12.1/	21162			USA		
(0	r Itan	Funerai		ied 2 Married	Armed Forces	?	13. 4	Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puerl	to Rican, etc.)	0-	14. Race - Am Black, Wh	
))	ours a	þ	3 🗆 Widowed	4 Divorced	If Yes, Give Year or Dates:		5 1	☐ Yes 2 🗓 No	Specify:			Specify: W	hite
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. do other than "natural", or Itams 23e or 28e-f show event. The Medical Evanirer must be notified at	Completed	(Ѕрес	15. Decedent's E cify only highest gra	ducation		6a. Deced	ent's Usual Occup kind of work done	oation during most of wor d)	rking	16b. Ki	nd of Busines	s/Industry
12	filed within Hygiene. ther than ont, the M	duc	Elementary/Seco	indary (0-12)	College (1-4or			tional Off:			r. 7.		
ğ	illed Hygi other	Be C	17. Father's Name ((First, Middle, Last			DELEC	LICIAL OIL	18. Mother's Nan	ne (First, Middle		imore Co	unty
/lar	Wenta Menta Menta arked	ToB	William Edv	ward Lumpk	in				Beaulah E	lizabeth	Gayle		
fan,	2 should be f and Mental to is marked of raumatic ever		19a. Informant's Na	ame/Relationship (Type, Print)	1	19b. Mailin	g Address (Street	and Number or Ru	ıral Route Numb	er, City or	Town, State,	Zip Code)
	ges 1 and 2 should it of Health and Men If itam 27 is marke or other traumatic		Kimberly St. 20a. Method of Disp					evenson Lar	ne Towson,	Maryland			
Baltimore,	permit. Pages Department of t Important: If its any Injury or or once.		1 🔀 Burial 2 [Cremation 3	Removal from State	ceme	etery, crem	atory or other plac	· 1	Date		cation - City or	
ij	artme ortan Injury		21. Jign ture of Full	5 Other (Specification of the Service Licer		Garde		Name and Addre	August 3	2005	Balt	imore, Ma	ryland
ñ	permit. Departr Imports any Inji		Marin	V Stormer	- Abana	·V:	La	assahn Fund	eral Home I				
4			23a. Part1. Enter the	ne disease, or com	olications that caused one cause on each ti	d the death. D	o not ente	Of Belair or the mode of dyin	Road Balting, such as cardiac	more Mary or respiratory a	land 2	21236	Approximate Interval Between
E	Physician		Immediate Cause (disease or condition	Final	PANC		tic	CANC	GR WITH	4 METAS	TASIS	TOLIK	
	/Medical Examiner		resulting in death)		ue to (or as	a consequenc							1
		er	Sequentially list con if any, leading to im cause. Enter Under	nditions,	b. Due to (or as	a consequenc	ce of):						
	d ansit	Examiner	cause. Enter Under Cause (Disease or i that initiated events	injury		,	.,						
60,	be executed sician and burial-transit		resulting in death) L		C Due to (or as	a consequenc	ce of):						
9289	cate by	Physician/Medical			d								
9 ×	leath certificate t attending physi I for use as the b	/Me	IF FEMALE:	T.	23c. If yes, outcome	of orognosou							
Вох	atten for u	cian	in the past 12 r	months?	1 Live birth	2 Fetal dea		Ectopic pregnancy Other (specify)			2:	3d. Date of de Month	livery Day Year
д. О.	t the c by the achec	hysi	1 ☐ Yes 2 ☐ 9 ☐ Unknown	JNO	9□ Unknown								
λ, T	The law requires that the death certificate tte has been signed by the attending physbage 2 should be detached for use as the	by P	Part II. Other signifi	cant conditions o	ontributing to death b	ut not resulting	g in the und	derlying cause givi	en in Part I.	23e. Did to	obacco us	e contribute to	the cause of death?
ord	w require been significations	ted	(/\\\\\\\	MIN DE	STIGND BY	NT D	10130	5768 M	16UTU	1 10	∕es 2□	No 3□Pr	obably (Unknown
Vital Records,	e law r has be	Completed								24a. Was		24b. Were au	stopsy findings available completion of cause of
E	iician: The I certificate ha rector, page										rmed? 21 No	death?	
5	ysician: is certific director,	o Be	25. Was case referre		Hospital: Inpatie			3C DOA Othe	26. Place of Dear				
ō	y Phys er this eral di	\vdash	1 Yes 222. Manner of Death	NO .	28a. Date of Injui (Month, Day		Outpatient Time of	3☐ DOA 28c. Injury	4 Nulsing He	ome 5 Resid			cify)
0	ttending P death. tor: After I the funera	atlo	2 Accident	5 Pending investigation		y Year)	Injury	Work	<br Yes 2 □ No		,,		
Division of	I or Attendate after death Director:	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inju	ury - At home, c. (Specify)	farm, stree	et, factory, office		28f. Location (S City or Tox	Street and	Number or Ru	ıral Route Number,
	oital or urs afte oral Dir lled in				l .						,		
	To the Hospital or Attending Physicien: To the Funeral Director: After this certification to the Funeral Director: After this certification that the funeral director; the funer	edical	29a. Certifier (Check only one)	Certifying Ph 2 Medical Exam	ysician: To the best on hiner: On the basis of and manner sta	examination a	lge, death o and/or inve	occurred at the time estigation, in my op	ne, date and place, pinion, death occur	and due to the dred at the time, d	ause(s) a date and p	ind manner as place, and due	stated. to the cause(s)
	ro tha	Me	29b. Signature and t		A A	/		29c. License				signed (Monti	
	, \		•)	HLt.	her!	MD	7.	26191		7/	29/2	2005
11	14		30. Name and addre	ss of person who	completed cause of de	eath (Item 23a) (Type, Pi				-1	-11-	
1	,	•		7. SIRITH	ARA,211	2 B61	LAIRI	COAD, SUI	7810, FX	oustor	M	1210	47
Ì.	Sta Registra		31. Date filed (Month	AUG 1 3 2	2005 32. Sgistra	ar's Signatur	4	de					

15036		For	State of Maryla				Mental Hy	/giene	Э	
		1 - State Registrar		Ce	rtificate of	Death		Reg. No	2005	25232
Physicia /Medic		1. Decedent's Name (First, Middle, Las Rolf	Erick	1	Lehmann		2. Date of D Month July 2	Da	y Year 2005	9:41 p ^M
Examin		4a. Facility Name (If not institution, give				r Location of Dea		40	. County of Death)
		Frederick Memori	*	- In a birth day	Frede:		S 0 D-1 (D)		ederick	
Funeral Director		5. Social Security Number 6. S 346 - 62 - 2806	TOTAL SET	rs. last birthday) 44 Yrs.	Months Days	Hours Min		ay, Year)		pplace (State or Foreign untry) inois
and W		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation					10d. Inside City Limits
er death with the Marylan Iteme 23a or 28a-f show ner must be notified at	for	Maryland Frederi		Frede						1 ☐ Yes 2 🛣 No
r 28a	Irec	10e. Street and Number			10f. Zip Code			10g. Cit	tizen of What Cou	intry?
23a c	ralD	6906 Doublebrand	Court			21703			U.S.A.	
is 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mentall Hygiene. The fleath of the marked other then "natural, or Items 23s or 28s-f show other traumatic event, the Madical Examinational be notified.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Marned 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 10 Yes 2 No 10 If Yes, Give Year or Dates:	980 - 988	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🌠 No	lispanic Origin? (! an, Mexican, Pue Specify:	Specify Yes or N rto Rican, etc.)	0-	14. Race - Ameri Black, White Specify:	
72 hours aft		15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occup	pation		16b. K	ind of Business/Ir	
thin 7:	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retired ellite Te	d) -		C	ommunica	tions
led wi		12 17. Father's Name (First, Middle, Last)		Sate	silite te		I me (First, Middle			LIONS
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other then eny injury or other traumatic event, the Magnee.	To Be	Oswald F		nann		Erika		R		lein
2 should and Men Is marke	Ĕ	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street	and Number or R	lural Route Numb	er, City o	or Town, State, Zi	p Code)
and 2 salth a		Thelma Tavarez Le			Doublebr	and Ct,	Frederi	ck,	Maryland	1 21703
Pages 1: nent of He int: If Iten		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	-	matory or other plac	1	Date		ocation - City or T	
it. Pag rtmen rtent: njury		4 □ Donation 5 □ Other (Specify 21. Signature of up ral Service Lic.)	St St	nithsbur	cg Cremat	ory Jul	30,2005	Smi	thsburg,	Maryland
permit. Departu Imports eny ink		Hollin L	\mathcal{U} \rightarrow	706 10	Name and Addre Keeney & O6 East C	Basford	P.A. Fi	mera	al Home	nd 21701
		23a. Part 1. Enter the disease, or com- shock, or heart failure. List only	plications that caused the de	eath. Do not ent	er the mode of dyin	ng, such as cardia	c or respiratory	arrest,	, mary rai	Approximate Interval Between
_ Physician		Immediate Cause (Final disease or condition	a DANCREAT							Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a cons							
	ē	Sequentially list conditions, if any, leading to immediate	b. ALCOHO Due to (or as a cons							
uted	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c							
cete be executed chysician and the burial-transit	Exe	resulting in death) Last	Due to (or as a cons	equence of):						
cete b physic the b	dlcal	•	d							
certifi nding use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre						23d. Date of deliv	rery
death death ed for	lcia	in the past 12 months?	1 Live birth 2 Fe		Ectopic pregnancy Other (specify)				Month	Day Year
requires that the death certification is seen signed by the attending should be detached for use as	Phys	9 Unknown	9∐Unknown	М						
signed d be d	ρ	Part II. Other significant conditions of HYPERTENS! O.A.		esulting in the u	nderlying cause giv	en in Part I.		Yes 2		the cause of death? bably 4 Nnknown
v requ	letec	THE COLUMN TO A	, , , , ,				24a. Was			opsy findings available
he law e hes age 2	Completed						auto	psy ormed?	prior to co	ompletion of cause of
ysicien: The	0	25. Was case referred to medical				26. Place of De	1 ☐ Yes	2 /21N 0 опе)	TLI Yes	2 NO
hysic his ce	ToB	examiner? 1 X Yes 2 ☐ No		☐ ER/Outpatien		4 Nursing I	7		6 ☐Other (Speci	fy)
ing P	0	27. Manner of Death 1. Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year,	28b. Time of Injury	Wor	yat k? Yes 2 □No	28d. Describe	how injur	y occurred	
death death y the	flcat	2 Accident investigation 3 Suicide 6 Could not be determined	· ·	home, farm, str		163 2 110	28f. Location (Street an	d Number or Run	al Route Number,
s after	Certification;	4 Homicide	building, etc. (Spe	cify)			City or To	wn, State)	
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours attendenth. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	edical (ysician: To the best of my k niner: On the basis of exam and manner stated.							
To the Comp	Ž	29b. Signature and title of certifier	•		29c. Licens				te signed (Month,	
16		> Unal2			OCM			эшу	26, 200	
157		30. Name and address of person who of AMA RU	ompleted cause of death (III	tem 23a) (Type,	Print) 111 Pe	enn Stre	et Balt	imor	e, Maryl	and 21201
Sta	13	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	7					
Registra 0HMH 17 Rev 1/20	500	AUG 0 3 2	005 June	B. A					-	
17 110V 1/2U	V 1		**							

DHMH 17 Rev 1/2001

ORIGINAL

51	54		1 = Stata Amend Item 78	State of M 8 per fh	Maryland / D G846 8-1	epartmen Oe05iical	t of H <i>e of L</i>	ealth a	and M	lental Hy	ygien Reg. N	e .201	15	252	31.
	Physici	an	1. Decedent's Name (First, Middle, Last Patrick Lela	")						2. Date of D	eath		Year	3. Time of	
	/Medio Examir		4a. Facility Name (If not institution, give FORT WASHINGTON HO	street and numbe				Location of		JÜLŸ	40	c. County o		0759 RGES	A M_
	Funeral Director		5. Social Security Number 6. Se	X 7.7	Age (In yrs. last birth	nday) If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D	irti 9–1 ay, Year	-1956 57	9. Birthp Coun Texa		r Foreign
	e Maryland a-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince (George's	10c. City, Town									0d. fnside Ci 1 ☐ Yes	•
	with the	Dire	10e. Street and Number 15805 John Dailey	Road		10f. Zip		607			_	itizen of Wi Unite			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23a or 28a-1 ehow important: if Item 27 is marked other than "natural", or Iteme 23a or 28a-1 ehow hy Injury or other traumatic event, the Medical Exeminar must be notified at ances.	by Funeral Director	11. Marital Status 1 Never Married XX Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force: 1 Yes 2 fi ff Yes, Give Ary Year or Dates	s? X No	13. Was Decer If Yes, spe- 1 \(\text{Yes} \)	dent of His		gin? (Spe i, Puerto l	ecify Yes or N Rican, etc.)		14. Race		an Indian,	
Maryland 21215-0036	within 72 housene. Than "nature to Medical E	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		r 5+)	Decedent's Usua (Give kind of wo life. DO NOT u	rk done a se retired,	lu <i>ri</i> ng mos)	t of workii	ng		Kind of Bus		dustry rernmen	nt
nd	be filed stal Hygie of other	Be	17. Father's Name (First, Middle, Last)	W C1 1				18. Mothe		(First, Middl	e, Maide	n Sumame		CTIME	.10
ıryla	should nd Men marke umatic	ဥ	Ralph Lama:			Mailing Address	(Street a			oyce B			tate, Zip	Çode)	
	and 2 sealth ar n 27 is		Mary McCluskey (V		15	805 Joh	n Da		Road	, Acco	keek	, MD	2060	7	
nore	Pages 1 nent of He int: If Iter iry or oth		20a. Method of Disposition 1 Burial XXI Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory Aug 6. 200							ate	10000	ocation - C	2011		9.0
Baltimore,	permit. P Departme Importan any Injury 2008.		1 — Burlai RAI Cremation 3 — Hemoval from State							Funera ad, Cl	1 Ho	me, I	nc.	ryland 6633 (735	1 01d
	Physician /Medical		23a Fart1. Enter the disease, or come shock, or heart failure. List out of the disease or condition resulting in death)	a. HyperAcus	ed the death. Do not line.	osclero						ease		Approximat Interval Bet Onset and I	ween
760,	wamine executed having-transit le privat-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequence of										
.O. Box 68	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death at time of death	3 □Ectopic pi 5 □ Other (sp						23d. Date Mont		,	Year
ords, P.	equires that en signed b ould be deta	۾	Part II. Other significant conditions co		but not resulting in	the underlying o	ause give	en in Part I				,		e cause of dably 4 🗆	
Division of Vital Records,	n: The law ru ficete has be rr, page 2 sh	e Completed	05 Wassesselson days of the							per 1⊠Yes	opsy formed? 2 \(\) N	pri	ere autor or to con ath? Yes	osy findings npfetion of c	avaifable ause of
f Vit	nysicia nis certi directo	To Be	25. Was case referred to medical examiner? 1. 1 Yes 2 □ No	Hospitaf: 1 ☐ fnpa	itient 2 ER/Out	patient 3X DC	Othe Othe	ar.		n <i>(Check</i> on <i>ly</i> me 5□Res		6 Other	(Specify	·)	
o uc	Jing Pt. J. After the		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Ir (Month, I	jury 28b. Ti Day Year) In	me of 2 jury M	28c. Injury Work	at ? Yes 2 🗆	i	28d. Describe	how inju	ury occurre	d		
Division	al or Attending s after death. I Director: After d in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of to	injury - At home, fare etc. (Specify)					28f. Location City or To			or Rura	l Route Num	ber,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	Medical C	(Check only 2 XMedical Exam	rsician: To the be- iner: On the basis and manner	st of my knowledge, of examination and stated.	Vor investigation	, in my op	oinion, dea	d place, a th occurre	and due to the ed at the time	, date ar	id place, ar	d due to	the cause(s	;)
)	To the within 2 To the complet	M	29b. Signature and title of certifier	Dee	P NO		OCM					uste signed	(Month, 1		
1	Sta	to	30. Name and address of person who of Tashu ZGreen be 31. Date filed (Month, Day, Year)	era M.D	, 111 PE	INN STRE		BALTI	MORE	, MARY	LAND	, 212	.01		
24	Registi		JUSTIC ROTEETISCH TOU												

			State of Maryland / Dep 1- State amend item #1 PER PHY G846	artment of Health and Me 3/1.0/05 Trificate of Death	ental Hygie Reg.	/ 11115	25235
	Physici		1. Decedent's Name (First, Middle, Last) William Luther	Doffinhanaan	2. Date of Death July 28,	Da 2005 Year	3. Time of Death 2:15 А. м
}	/Medic Examin		4a. Facility Name (If not institution, give street and number) 602 Rosemont Avenue	4b. City, Town, or Location of Death Frederick		4c. County of Death	ederick
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 204-03-4832 1X M 2 F 82 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Dec. 16,	9. Birthp	lace (State or Foreign try) 10
	yland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L			1	0d. Inside City Limits
	the Mar 28a-1 si	Director	Maryland Frederick 10e. Street and Number	Frederick	100	Cities - Clatter A Co	1X Yes 2 No
	23a or	ai Dir	602 Rosemont Avenue	21701	log.	Citizen of What Cour U .	S.A.
980	urs after dea el', or Items Exement	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R 1 ☐ Yes 2X No Specify:	ify Yes or No- ican, etc.)	14. Race - Americ Black, White, Specify: W	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23a or 28a-1 show any Injury or other treumatic sysnt, the Marical Exams and must be muffled at once.	Completed	(Specify only highest grade completed) (Give life.	dent's Usual Occupation a kind of work done during most of working DO NOT use retired) Crical salesman	Wh	olesale Di	•
nd 2	oe filed al Hygi d other svsnt, l	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name		mpany den Surname)	
ryla	hould be deminded the marked marked marked	ို	William L. Poffinberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ng Address (Street and Number or Rural	lice Kem		Codel
, Ma	and 2 s salth an 127 Is I er treu			2 Rosemont Avenue,			,
altimore,	Pages 1 ment of He ent: If item ury or oth		20a. Method of Disposition 20b. Place of Disposition Burial 2 Cremation 3 Removal from State Mt. Office of Complete, crewitary.			E. Location - City or To Frederick	
Balt	permit. Depart Import any Inj		Toward (. Bar for vicine)	² Name and Address of Facility Keeney & Bastord F 106 East Church St	reet. Fr		TO 21701
	Prrysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	certury die a cardiac or			Approximate Interval Between Onset and Death
	Examiner		Due to (or as a consequence of):	V			100 5
	uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter under this Cause (Disease or injury that initiated events				
8760,	icate be executed physician and s the burial-transit	dicai Exa	resulting in death) Last Due to (or as a consequence of):				
.O. Box 68	The law requires that the death certifica tte has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year
۵.	quires that I in signed by uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the Ce Kehrever West dideath	inderlying cause given in Part I.	23e. Did tobac	co use contribute to th	e cause of death?
Records,	e taw require has been si ge 2 should t	Completed	atunic paumahr		24a. Was an autopsy	prior to con	osy findings available inpletion of cause of
		Be Col	25. Was case referred to medical	26. Place of Death (performed	? death? No 1 □ Yes	2 🗆 No
Division of Vital	ing Phys ofter this uneral di	으	examiner? 1 Yes 2 No	ont 3 DOA Other: 4 Nursing Home		e 6 □Other (Specify njury occurred)
Division	o Dir	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		If. Location (Stree City or Town, S	t and Number or Rural tate)	Route Number,
	the Hospitel or hin 24 hours afte the Funerel Dire upletely filled in h	edicai	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, deal 2 Medical Exeminer: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, an vestigation, in my opinion, death occurred	d due to the cause I at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, L	Day, Year)
	7		30. Name and address of person who completed cause of death (Item 23a) (Type,			1/28/0	5
	U		Austin Pearre, M.D., 300 West	Ninth Street, Fred	erick, Ma	aryland 21	701
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 3 2005	inde			

			For State	State of Mar	yland /	Departme Certifica				jiene 109. N2 0 0 5	25236
	6		Registrar 1. Decedent's Name (First, Middle, La	st)					2. Date of Dea	th	3. Time of Death
М	Physici		Jack	Rev	er				Month O 7	28 20	05 5:50 pm.
-	/Medic Examin		4a. Facility Name (If not institution, giv			4b. Cit	y, Town, or L	ocation of Death		4c. County of D	eath
78			GOOD SAMARI	TAN HOSE	DITAL	- BA	ALTIN	IORE		Baltimo	ce City
	Funeral		Social Security Number 6. S		In yrs. last i	Month		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year) 9.	Birthplece (State or Foreign Country)
No.	Director			X ^{M 2□ F} 84		Yrs.			June 2	7,1921	Maryland
	and and		Usual Residence of Decedent 10a. State 10b. County	1	IOc. City, To	own or Location					10d. Inside City Limits
	Manyl f eho	ō	Maryland Baltimon	re		Baltimo:	re Cou	ntv			1 ☐ Yes 2 No
	288-	rect	10e. Street and Number				ip Code			10g. Citizen of What	Country?
	3a or	Funeral Director	11 Mopec Circle Ap	ot. B			21236			USA	
	death ms 2	nera	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. Was Dec	edent of His	panic Origin? (Spec , Mexican, Puerto R	ify Yes or No-		merican Indian, /hite, etc.
326	be filed within 72 hours after death with the Maryland ital hygiene. id other than "natural", or items 23e or 28e-f ehow event, I'm Medical Examinantinal termiliad at	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1√√Yes 2 □ No 1f Yes, Give Year or Dates:	WW 11		2 No	Specify:	iican, etc.		White
Maryland 21215-0036	2 ho	Completed	15. Decedent's E	ducation	16	Sa. Decedent's Us	ual Occupat	ion iring most of workin	a	16b. Kind of Busine	ss/Industry
2	filed within 72 Hygiene. other than "nater, in a Medic	ple	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT	use retired)	ming most or working	•	doctorn E	lectric Co.
2	filed with Hygiene. other than	Con	12 yrs.	N/A		Press S			1		Tectific co.
ğ	d off	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name Edna Mil		Meiden Sumame)	
<u>Ş</u>		70	Edward Rever 19a. Informant's Name/Relationship (Time Defeat		Oh Mailine Addre	na /Strant ar			r, City or Town, Stat	a Zin Coda)
Mai	an e ar				1					imore, Md	
	s 1 and 3 if Health item 27 other tr	1	Jean W. Rever (Wi:	re)	20b. Place	of Disposition (A	ame of	Da	ate	20c. Location - City	
פֿב	Pages nent of int: If it		X ⊠ Burial 2 ☐ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Special			itery, crematory o wood Cem		8~2~20	005	Baltimor	e. Md.
altimore,	그 문원를		21. Signature of Funeral Service Lice			22. Name	and Address	of Facility	1 -		·
ñ	Department Department		1. E. F. La	soakn		Lassal 7401	nn ⊦un Be⊥air	eral Home Rd. Balt	imore.	Md. 2123	0
è.	*		23a. Part1. Enter the disease, or com shock, or heart failure. List only	ORE CAUSE OF EACH INFO		o not enter the m	ode of dying,	such as cardiac or	respiratory arr		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CONGE	ESTI	VE HE	EART	FAILU	LRE		Onset and Death
В	/Medical		resulting in death)	Due to (or as a							10 0
	Examiner		Sequentially list conditions,	b. ISCH	EMI		CART	DisE	ASE		10 yR.
ip i	P #5	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequenc	ce of):					,
	and Ftrans	Examiner	that initiated events resulting in death) Last	c	consequenc	ce of):					
8760,	be ey										
587	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burfal-transit	edical		d						γ	
Вох	centi nding use a	√W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of						23d. Date of	delivery
m.	death e atte d for	by Physiclan/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at tir						Month	Day Year
0	t the by the tache	hys	9 Unknown	9 Unknown					-		
	signed I	Бу Р	Part II. Other significant conditions	contributing to death but	not resulting	g in the underlying	cause giver	n in Part I.			e to the cause of death?
ord	v require been si should l							-	1 U Y	es 2 ⊠No 3 □	Probably 4 Unknown
Records,	e law r has be je 2 sh	ple							24a. Was a autop	sy prior	autopsy findings available to completion of cause of
	the cate h	Completed							perfor 1 Yes	med? deat	7es 2□No
Vita	ician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Other	26. Place of Death	(Check only or	10)	
	Phys this al dir	To To	1 Yes 2 No	1 Inpatient 28a. Date of Injury		Outpatient 3	28c. injury	4 Nursing Hom		ence 6 Other (5 ow injury occurred	Specify)
no	ding P. After funer	tion	1 Natural 5 Pending	(Month, Day	Yeer)	Injury M	Work	es 2 🗆 No		on many coodings	
Division of	f or Attandi after death. Director: A I in by the fu	flca	3 Suicide 6 Could not 8	e 28e. Place of Injury	y - At home,	, farm, street, fact	ory, office	2			r Rural Route Number,
á	afor A after Direct d in by	Certification:	4 Homicide	building, etc.	(Specity)				City or Tow	n, State)	
	To the Hospital or Attanding Physician: The la within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical (nysician: To the best of miner: On the basis of e and manner state	xamination						
ì	To th To th	Me	29b. Signature and tyle of certifier	ed a	nec	1	9c. License 0 3 7	280	2	29d. Date signed (M	onth, Day, Year)
1	Stat		30. Name and address of person who	completed cause of dea	560	a) (Type, Print)	+ RAI	IEN BL	VD. B	ALTO, MI) 21239
	Sta Registi		31. Date filed (Month Day Year) AUG 0 3	32. Pojistrar			ر ا				
DH	MH 17 Bev 1/2			Jacobs		- Andrew					

			1- State of Mary		artment of Heartificate of De			000	05007
			Registrar 1. Decedent's Name (First, Middle, Last)		Tillicate of De	zaii i	Reg. 2. Date of Death		3. Time of Death
	Physici /Medio		ROSLYN		ROSENBERG		JULY 31		4:14 P M
	Examir	er	4a. Facility Name (If not institution, give street and number) 10 COBBLER COURT		4b. City, Town, or Lo	cation of Death BALTIMOR	RF	4c. County of Death	TIMORE
Ī	Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year If	Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye		place (State or Foreign
	Director		220-38-7492 1□ M 2 M F Usual Residence of Decedent	63 Yrs.		TOUTO IVIII.	OCT.8,194	11	MD
	iryland show	_	10a. State 10b. County 10	c. City, Town or Lo					10d. Inside City Limits
	the Ma 28e-1	Director	MD BALTIMORE 10e. Street and Number	BALT	10f. Zip Code		10	0	1 □Yes 2 No
	h with	a Di	10 COBBLER COURT			21208	Tog.	Citizen of What Cou	USA
	tems	Funeral	11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of Hispa If Yes, specify Cuban, N	anic Origin? (Spe Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
5-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "neturel; or Items 23e or 28e-1 show event, I'm Medical Examiner must be notified at	þ	1 💢 Never Married 2 □ Married 1 □ Yes 2 💢 No 1 □ Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:		1 ☐ Yes 2 🎇 No S	Specify:		Specify:	WHITE
2-0	"netur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decer (Give	dent's Usual Occupation kind of work done durin DO NOT use retired)	n ng most of worki	ing 16b	. Kind of Business/in	ndustry
72.	iene. r then	omp	Elementary/Secondary (0-12) College (1-4or 5+)		DO NOT use retired) UNTANT			AW OFFICE	
מפ	m = 0 %	BeC	17. Father's Name (First, Middle, Last)		18	3. Mother's Name	(First, Middle, Maid	den Sumame)	
Maryland	Mer Mer etic	ို	HARRY 19a. Informant's Name/Relationship (Type, Print)			FREDA	(S- 4- M		OLDBERG
	hall hall		ERIC ROSENBERG / NEPHEW		ng Address (Street and) 1 SUMMER C				
ore,	of Hold Hiter		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State	0b. Place of Dispo	sition (Name of matory or other place)	ļ	Date 20c	. Location - City or T	own, State
altimore,	Pa ent ury		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Euneral Service Licensee		HEBREW CE			REISTERST	
g	permit. Departimport any inj		Source Cleaning		Name and Address on REISTER				
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.						Approximate Interval Between
ŧ	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	· My	ocerdi	1-Into	netron		Onset and Death
	Examiner		Due to (or as a co	nsequence of):					
	ed sit	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	nsequence of):				1	
,	execut n and ial-tran	Examiner	that initiated events resulting in death) Last C. Due to (or as a co	nsequence of):			-		
2/8 2/8	cate be executed physician and the burial-transit	dical	d						
٥		/Mec	IF FEMALE: 23c. If yes, outcome of p.	regnancy				02d Date of deliv	
. Box	that the death certifi ed by the attending detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
r Ö	hat the d by th		9 ☐ Unknown 9 ☐ Unknown 9☐ Unknown Part II. Other significant conditions contributing to death but no	t consisting in the su	adark in a sauce sure in	- D1	220 Did tabasa		h
ds,	es De g	d by	Takin. Silen significant containing contributing to death but no	tresulting in the di	idenying cause giveri ir	n ran i.		2 No 3 Prol	pably 4 Unknown
ecord	aw as b 2 si	ompleted					24a. Was an autopsy	24b. Were auto	opsy findings available impletion of cause of
T,	The ate h page	Com					performed	? death?	
VII	Physiclen: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 🗋 ER/Outpatien	Other		(Check only one)	o (T) 011 - 1/2	
10 L	ding Phys h. After this funeral di	\vdash	27. Many of Death 1 Natural 5 Pending (Month, Day Yes	28b. Time of	the service		ne 5 Aesidence 28d. Describe how in		y)
UNISION		ertification;	2 Accident investigation 3 Suicide 6 Could not be		M 1 ☐ Yes	2 □ No	306 L (Character		15
<u>≥</u>	el or A s after al Direct	Certif	4 Homicide determined 28e. Place of Injury - building, etc. (S	Decify)	eet, ractory, omce	4	City or Town, St.	and Number or Rura ate)	i Houte Number,
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my one and manger stated.	rknowledge, death mination and/or inv	occurred at the time, overtigation, in my opinion	date and place, a on, death occurre	and due to the cause ed at the time, date a	o(s) and manner as s and place, and due to	tated. the cause(s)
	To the within To the comp	N N	29b. Signature and title of certifier		29c. License nu	ımber	29d. [Date signed (Month,	Day, Year)
7	2		30 Name and address of across who are	//tom #0-1 77		307	7 8	5/1105	
	600		30. Name and address of person who completed cause of death	VAIST	ERS W	ILL P	1 + 135	OM, MC	1 2117
	Sta Registr	_	AUG 0.3 2005	ignature	de	,		.)	7 1 1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State	or mary	•	ertificate of			Reg. 20.00	5 25	238
H	Physici		Decedent's Name (First, Mide Keum	dle, Last) Song					2. Dete of De Month 07/31	Dev	Year	ime of Death :40 pm
	/Medic Examir		4a Facility Neme (If not institution 21930 Greenbr		ımber)			4b. City, Town, or I Boyds	-	h 4c. County		L.
	Funeral Director		5. Social Security Number 533–72–6727	6. Sex 1 ☐ M 2 ☑ F	7. Age (In 89	yrs. lest birthday Yrs.	/ If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di 3/3/1	rth ay, <i>Year)</i> 916		State or Foreign Korea
	Maryland a-f show	tor	Usuel Residence of Decedent 10a. Stete 10b. Count MD	y Montgomer		c. City, Town or L	ocation Boyds					side City Limits
	3a or 28	I Dire	10e. Street and Number 21930 Green	brook Driv	<i>r</i> e		10f. Zip Code	0841		10g. Citizen of	Whet Country? JSA	
036	permit. Pagas 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mantel Hygiena. Important: if Item 27 is marked other than "naturel", or items 23a or 28e-f show simply journy or other traumatic event, the Medical Examiner must be recified at ance.	To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Me 3 ☑ Widowed 4 □ Divorce	If Yes G	orces? 2 X No ive	r in U,S. 13	Was Decedent of I If Yes, specify Cub		pecify Yes or No o Rican, etc.)	5 14. Rac Bla	ce - American Ind ck, White, etc.	
Baltimore, Maryland 21215-0036	I within 72 ho lana. ' than "natur the Medical I	ompleted	15. Decede (Specify only high Elementery/Secondary (0-12) 12	ent's Education lest grade completed) College (1-4or 5+)	16e. Dec (Giv life.	edent's Usual Occup e kind of work done DO NOT use retire HOMEMAKE:	d)	king	16b. Kind of B	own Hom	
and ?	id be filed antel Hyg ked other ic event,	o Be C	17. Fether's Neme (First, Middle Heayong Jeo					18. Mother's Nan	ne <i>(First, Middle</i> 1 Si	, Maiden Suman	ne)	
Mary	nd 2 shou Ith end M 27 is mer		19a. Informant's Name/Reletion Susie Tam /	nship <i>(Type, Print)</i> Daughter		19b. Mai 219	ling Address (Street 30 Greenb	rand Number or Ru rook Driv	ral Route Numb	er, City or Town, s Maryla	, State, Zip Code and 2084	11
imore,	Pagas 1 er nant of Hea int: If Item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (State 1	cob. Place of Disposers, critical August 1990 (1990) Place of Disposers (1990) Place of Disposer	position (Name of ematory or other pla Memorial	Park 08	Date 5/5/2005	20c. Location New Be	City or Town, S erlin,	state WI
Balt	permit. Depertrainmonts eny inju		21. Sometiment Service	LEOSUE Victo	T.P.	Doda, Jr	Chartes	ess of Fecility L. Steve Fort Ave	ens Func enue, Ba	eral Hom altimore	e Inc. MD 2123	30
	Physician /Medical Examiner		23a. Part1. Enter the disease, shock, or heart tailure. List Immediate Ceuse (Final disease or condition resulting in death)	or complications that st only one cause on a.	eech line.	death. Do not el	2 100		c or respiratory a	arrest,	Inter	roximate val Between et and Death
ox 68760,	certificate be executed rding physician and ise as the burial-transit	√Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last	b		to (or es e conse						
. Box	daath e attar id for u	lciar	Part II. Other significant condit	tions contributing to d	eath but no	ot resulting in the	underlying cause gi	ven in Pert I.	23b. Did	tobacco uee co	ntribute to the	cause of death?
0. 0.	that tha	y Phys							10	Yes 20XNo	3 Probably	4 ☐ Unknown
Division of Vital Records, P.O.	The lew requires that tha death certif ste has been signed by the attanding paga 2 should be detached for use a	Completed by Physician/M								s en eutopsy ormed?	available	utopsy findings a prior to ion of cause ?
Æ æ	The la	Com							+0	Yes 2.Nuu	1 ☐ Yes	250 No
<u> </u>	cartifi rector	o Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Innationt	2 ☐ ER/Outpatio	ent 3 DOA Ot	26. Place of Dea		one) idence 6 □Oth	or (Coosifu)	-
ion of	To the Hospital or Attending Physicien: The lew within 24 hours after death. To the Funerel Director: After this cartificate has completely filled in by the funerel director, pega 2	atlon: To	27. Manner of Deeth 1 ☑Natural 5 ☐ Pend	28e. Dete	of Injury oth, Dey Ye		of 28c. Inju		-	how injury occur		
Divis	al or Atters a ster date	Medical Certification:	3 ☐ Suicide 6 ☐ Could deter	mined 200, Place	e of Injury - ling, etc. (S	At home, farm, s Specify)	treet, factory, office			(Street and Numi wn, State)	ber or Rural Rou	te Number,
	he Hospit in 24 hours he Funere pletaly fille	edical (29a. Certifier (Check only one) 15 Certify 2 Medica	ing Physician: To the il Examiner: On the b and mer	best of moses of example of examp	mination end/or i	ith occurred at the ti nvestigation, in my	me, dete end place opinion, death occu	, end due to the irred et the time,	cause(s) and ma , date end place,	anner as steted. and due to the o	euse(s)
	With To th	Σ	29b. Signature end title of certifi	ier (29c. Licen				od (Month, Day,	
1	1		30. Neme end eddress of perso	n who completed cau	se of death	(Item 23e) (Type		005128			•	0850
1	Sta	ite.	31. Date filed (Month, Day, Yea	r) 32. F	Regiotrer's	Signature		ed Cen Dr	rive Sui	te 201 I	_	
	Registi		AUG	0 3 2005	Maria	co K	Coule					

DHMH 16 Rev 6/95

ORIGINAL

			For State	State of Ma	,	partment of F		nd Mental Hy	giene	
			State Registrar 1. Decedent's Name (First, Middle, L.)	aet)	Ce	ertificate of	Death	2. Date of De.	Reg. No.2	05 25229
	Physici	an						Month O'7	Day	Year IZ: 1 2 A.M.
	/Medic		Nellie K. 4a. Facility Name (If not institution, gi	Spangler		4b. City, Town, o	r Location of I		4c. Count	y of Death
	Examin	er	SACred NeA		tai	1 1		201		GAN
	Funeral			Sex 7. Age	(In yrs. last birthda)	y) If Under 1 Year	If Under 24	Hrs. 8. Date of Birt	h W Yearl	9 Rintholana (State or Foreign
	Director		234-46-6694	1□M 20XF	85 Yrs.	Months Days	Hours	Min. 8. Date of Birt (Month, Da Feb. 2	6,1920	West Virginia
	p ,		Usual Residence of Decedent 10a. State 10b. County		100 City Taylor and	1				404 (
	shov	-			10c. City, Town or I					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Ba-f	ectc	WV Grant		New C				40	
	with t	급	10e. Street and Number			10f. Zip Code	7/2			What Country?
	ours after death with the Maryland eat, or Itams 23e or 28e-f show Examiner must be mollified at	Funeral Director	HC 72, Box 210	12. Was Decedent Ex	ver in U.S. 13		743 Hispanic Origin	1? (Specify Yes or No	USA	Lce - American Indian,
10	r Itan	臣	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 X No				n? (Specify Yes or No Puerto Rican, etc.)	Bla	ack, White, etc.
936	urs a	þ	3X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Speci	Mhite
215-0036		Completed	15. Decedent's t (Specify only highest g	Education	16a. Dec	cedent's Usual Occup ve kind of work done	ation	if working	16b. Kind of E	Business/Industry
2	within ene. than "	npie	Elementary/Secondary (0-12)	College (1-4or 5+	-) life.	. DO NOT use retired	d)			
7	filed w Hygier othar th	S	3		Н	lomemaker	40. 11-11-1	No. of Contract of		Own Home
gu	be fill	Be	17. Father's Name (First, Middle, Las					Name (First, Middle,		•
3	should man Men s marka umatic	2	Clarence Samue		405.14-1	::: Add (Oh)		hel Judith		
Maryland	C1 00 22 00		19a. Informant's Name/Relationship Sandra Ebert Arn	* **				or Rural Route Numbe		
	1 and Health am 27 thar tr		20a. Method of Disposition	old/Daughte.	20b. Place of Disp	IC 72, Box position (Name of		New Creek,		743 - City or Town, State
nor	Pages nent of I nnt: If Itu		1 X Burial 2 ☐ Cremation 3		cemetery, cr	rematory or other place		July 29		
Baltimore,	it. P rtme rtan rijury		* 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice	-	Action to the second second second second	t Memorial 22. Name and Addre		2005		rland, MD
B	permit. Departr Importa		Buil	P. Soul	TE			Smith Fu Street Ke		
1			23a. Part1. Enter the disease, or conshock, or heart failure. List only	mplications that caused t	the death. Do not e					Approximate
				v one cause on each line		into into into do or dy ii	ig, such as co	itulac or respiratory at	1031,	
1	Direction of the last		Immediate Cause (Final	2. 1					1651,	Interval Between Onset and Deat
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a out	consequent of):				1651,	Interval Between
			disease or condition resulting in death)	a out	e myon				1031,	Interval Between
	/Medical Examiner	ner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a out	e myon			2	1031,	Interval Between
	/Medical Examiner	aminer	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	a	consequence of):				1031,	Interval Between
	/Medical Examiner	i Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury	a	e myon				1031,	Interval Between
8760,	/Medical Examiner	icai	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	a	consequence of):					Interval Between
68760,	/Medical Examiner	edicai	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	a. Due to (or as a b. Due to (or as a d.	consequence of): consequence of):					Interval Between Onset and Dead Month
68760,	/Medical Examiner	edicai	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Unide lying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	a	consequence of): consequence of): consequence of):	shil inf	extended de		23d. Da	Interval Between
Box 68760,	/Medical Examiner	edicai	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	a	consequence of): consequence of): consequence of):	abil information	extended de		23d. Da	Interval Between Onset and Dead! World Green August ate of delivery
P.O. Box 68760,	/Medical Examiner	Physician/Medicai	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No	a. Due to (or as a b. Due to (or laid) C. Due to (or as a d. 23c. If yes, outcome of the control of the contro	consequence of): consequence of): consequence of): f pregnancy Fetal death 3 ime of death 5	B Ectopic pregnancy	weter	Pirpere	23d. Da M:	Interval Between Onset and Dead! World Green August ate of delivery
P.O. Box 68760,	/Medical Examiner	by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uniterlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	a. Due to (or as a b. Due to (or laid) C. Due to (or as a d. 23c. If yes, outcome of the control of the contro	consequence of): consequence of): consequence of): f pregnancy Fetal death 3 ime of death 5	B Ectopic pregnancy	weter	23e. Did to	23d. Da M:	ate of delivery onth Day Year
P.O. Box 68760,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uniterlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	a. Due to (or as a b. Due to (or laid) C. Due to (or as a d. 23c. If yes, outcome of the control of the contro	consequence of): consequence of): consequence of): f pregnancy Fetal death 3 ime of death 5	B Ectopic pregnancy	weter	23a. Did to	23d. Da Mi obacco use con ∕es 2 □ No	ate of delivery onth Day Year
P.O. Box 68760,	raw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uniterlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	a. Due to (or as a b. Due to (or laid) C. Due to (or as a d. 23c. If yes, outcome of the control of the contro	consequence of): consequence of): consequence of): f pregnancy Fetal death 3 ime of death 5	B Ectopic pregnancy	weter	23e. Did to 1 1 1 24a. Was autor perfo	23d. Da Mi bbacco use con (es 2 \(\sum \) No an 24b. isy	ate of delivery onth Day Year atribute to the cause of death? The probably 4 Unknown Were autopsy findings available prior to completion of cause of death?
Records, P.O. Box 68760,	raw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions	a. Due to (or as a b. Due to (or laid) C. Due to (or as a d. 23c. If yes, outcome of the control of the contro	consequence of): consequence of): consequence of): f pregnancy Fetal death 3 ime of death 5	B Ectopic pregnancy	en in Part I.	23e. Did to 1 1 24a. Was autor perfo 1 1 Yes	23d. Da Mi obacco use con (es 2 □ No an asy rmed? 2 (X No	ate of delivery onth Day Year Atribute to the cause of death? The probably 4 Dunknown Were autopsy findings available prior to completion of cause of
Vital Records, P.O. Box 68760,	raw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uniterlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Dther significant conditions Chomic 25. Was case referred to medical examiner?	a. Due to (or as a b. Due to (or laid) C. Due to (or as a d. 23c. If yes, outcome of the pregnant at time of the pregnant at	consequence of): consequence of): consequence of): f pregnancy Fetal death irre of death t pet resulting in the	B Ectopic pregnancy Cother (specify)	en in Part I.	23a. Did to 1 \(\text{1} \) 24a. Was autor perfo 1 \(\text{Yes} \) f Death (Check only o	23d. Da Mi Dibacco use con (es 2 \sum No an ssy rmed? 2 \textbf{XNo} ne)	ate of delivery onth Day Year Atribute to the cause of death? Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Vital Records, P.O. Box 68760,	Physician: The law requires that the death certificate be executed the contribution of the certificate has been signed by the attending physician and contribution in the certificate has been signed by the attending physician and contribution in the certificate has been signed by the attending physician and contribution in the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate be executed by the certificate has been signed by the certificate by the certificate has been signed by the certificate by the certificate has been signed by the attending physician and certificate has been signed by the attending physician and certificate has been signed by the attending physician and certificate has been signed by the attending physician and certificate has been signed by the attending physician and certificate has been signed by the attending physician and certificate has been signed by the attending physician and certificate has been signed by the attending physician and certificate has been signed by the certification of the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the c	To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undersying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Dther significant conditions Choose 25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death	a. Due to (or as a b. Due to (or as a d. 23c. If yes, outcome o 1 Live birth 2 4 Pregnant at ti 9 Unknown contributing to death but	consequence of): consequence of): consequence of): f pregnancy	B Ectopic pregnancy Other (specify) underlying cause give	en in Part I. 26. Place o	23e. Did to 1 1 24a. Was autor perfo 1 1 Yes	23d. Da Mi bbacco use con fes 2 \(\text{No}\) an ssy rmed? 2 \(\text{No}\) tence 6 \(\text{Ott}\)	ate of delivery onth Day Year htribute to the cause of death? Probably 4 Dunknown Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Vital Records, P.O. Box 68760,	Aling Physician: The law requires that the death certificate be executed by the attending physician and a refer this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uniterlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a b. Due to (or as a d. 23c. If yes, outcome o 1 Live birth 2 4 Pregnant at ti 9 Unknown contributing to death but	consequence of): consequence of): consequence of): f pregnancy	B Ectopic pregnancy Dother (specify) underlying cause give underlying cause give and	en in Part I. 26. Place o	23e. Did to 1 1 24a. Was autor perfo 1 1 1 se f Death (Check only of ing Home 5 Resid	23d. Da Mi bbacco use con fes 2 \(\text{No}\) an ssy rmed? 2 \(\text{No}\) tence 6 \(\text{Ott}\)	ate of delivery onth Day Year htribute to the cause of death? Probably 4 Dunknown Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Vital Records, P.O. Box 68760,	Aling Physician: The law requires that the death certificate be executed by the attending physician and a refer this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uniterlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a b. Due to (or as a d. Due to (or	consequence of): consequence of): consequence of): f pregnancy Fetal death 3 irre of death 5 t out resulting in the state of the	B Ectopic pregnancy Dother (specify) underlying cause give underlying cause give and	26. Place o	23e. Did to 1 1 24a. Was autor perfo 1 Yes f Death (Check only of ing Home 5 Resid 28d. Describe h	23d. Da Mi Dibacco use con (es 2 \(\text{No} \) an sy med? 2 \(\text{No} \) dence 6 \(\text{Ott} \) now injury occur Street and Num.	ate of delivery onth Day Year htribute to the cause of death? Probably 4 Dunknown Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Records, P.O. Box 68760,	Aling Physician: The law requires that the death certificate be executed by the attending physician and a refer this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uniterlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a b. Due to (or as a d. Due to (or	consequence of): consequence of): consequence of): f pregnancy Fetal death 3 irre of death 5 t out resulting in the state of the	B Ectopic pregnancy Other (specify) underlying cause given Lying ent 3 DOA of 28c. Injur Mor	26. Place o	23e. Did to 1 24a. Was autor perfo 1 Ves f Death (Check only or ing Home 5 Resic 28d. Describe f	23d. Da Mi Dibacco use con (es 2 \(\text{No} \) an sy med? 2 \(\text{No} \) dence 6 \(\text{Ott} \) now injury occur Street and Num.	ate of delivery onth Day Year Approbably 4 Unknown Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Vital Records, P.O. Box 68760,	Aling Physician: The law requires that the death certificate be executed by the attending physician and a refer this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Unite-lying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a b. Due to (or as a d. 23c. If yes, outcome o 1 Live birth 2 4 Pregnant at ti 9 Unknown contributing to death but Contributing to death but 28a. Date of Injury (Month, Day on be 28b. Place of Injury (Month, Day on be 28b. Place of Injury (Month, Day on be 28c. Place of Injury (Month, Day on be 28c. Place of Injury (Month, Day on be 28c. Place of Injury (Month, Day on be 28c. Place of Injury (Month, Day on be	consequence of): consequence of): consequence of): consequence of): of pregnancy consequence of pregnancy consequence	B Ectopic pregnancy C Other (specify) underlying cause give un	26. Place o er: 4 \sum \text{Nurs} y at k? Yes 2 \sum \text{No.}	23e. Did to 1 1 24a. Was autor perfo 1 Yes f Death (Check only or ing Home 5 Resid 28d. Describe f 28f. Location (\$ City or Tov	23d. Da Minobacco use con Mes 2 No an say med? 2 No dence 6 Otto now injury occur with the control of the contr	ate of delivery onth Day Year atribute to the cause of death? Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No ther (Specify) rred there or Rural Route Number,
Vital Records, P.O. Box 68760,	Hospital or Attanding Physician: The law requires that the death certificate be executed to a hours after death. Funeral Director: After this certificate has been signed by the attending physician and prince the funeral director. After this certificate has been signed by the attending physician and prince the funeral director, page 2 should be detached for use as the buriat-transit or the funeral director.	Certification: To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Unite-lying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a b. Due to (or as a d. Due to (or	consequence of): consequence of): consequence of): consequence of): f pregnancy the pregnancy th	B Ectopic pregnancy D Other (specify) underlying cause give u	26, Place of the state of the state and pointion, death	23e. Did to 1 1 24a. Was autoperfor 1 1 Yes f Death (Check only of 28d. Describe to 28f. Location (Society or Town) 28f. Location (society or Town) 28f. Location (society or Town) 28f. Location (society or Town) 28f. Location (society or Town) 28f. Location (society or Town) 28f. Location (society or Town)	23d. Da Mino Dibacco use con Mes 2 No an esy med? 2 No one) dence 6 Otto now injury occur. Street and Number, State)	ate of delivery onth Day Year atribute to the cause of death? Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No her (Specify) rred the or Rural Route Number, the autopsy findings available prior to completion of cause of death? and death?
Vital Records, P.O. Box 68760,	Attanding Physician: The law requires that the death certificate be executed to death. To death. Sector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the buriat-transit	To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Unite-lying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a b. Due to (or as a b. Due to (or as a d. 23c. If yes, outcome or 1	consequence of): consequence of): consequence of): f pregnancy Fetal death 3 irre of death 5 t of resulting in the start resulting in the line of the line o	ent 3 DOA of 28c. Injury Work M 1 street, factory, office ath occurred at the tir investigation, in my of 29c. Licens	26. Place of left 4 Nurs y at k? Yes 2 No	23e. Did to 1 24a. Was autor perfo 1 Ves f Death (Check only or ing Home 5 Resid 28d. Describe for City or Tov	23d. Daty signe	ate of delivery onth Day Year Arribute to the cause of death? Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No her (Specify) rred there or Rural Route Number, thanner as stated, and due to the cause(s) ed (Month, Day, Year)
Vital Records, P.O. Box 68760,	Hospital or Attanding Physician: The law requires that the death certificate be executed to a hours after death. Funeral Director: After this certificate has been signed by the attending physician and prince the funeral director. After this certificate has been signed by the attending physician and prince the funeral director, page 2 should be detached for use as the buriat-transit or the funeral director.	Certification: To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uniterlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a b. Due to (or as a d. 23c. If yes, outcome or 1 Live birth 2 4 Pregnant at ti 9 Unknown contributing to death but Contributing to death but 28a. Date of Injury (Month, Day on be 28e. Place of Injury building, etc. Physician: To the best of and manner state	consequence of): consequence of): consequence of): f pregnancy Fetal death 3 irre of death 5 t of resulting in the start resulting in the line of the line o	ent 3 DOA of 28c. Injury Work M 1 street, factory, office ath occurred at the tir investigation, in my of 29c. Licens	26. Place of left 4 Nurs y at k? Yes 2 No	23e. Did to 1 24a. Was autor perfo 1 Ves f Death (Check only or ing Home 5 Resid 28d. Describe for City or Tov	23d. Daty signe	ate of delivery onth Day Year Arribute to the cause of death? Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No her (Specify) rred there or Rural Route Number, thanner as stated, and due to the cause(s) ed (Month, Day, Year)
Vital Records, P.O. Box 68760,	Hospital or Attanding Physician: The law requires that the death certificate be executed to a hours after death. Funeral Director: After this certificate has been signed by the attending physician and prince the funeral director. After this certificate has been signed by the attending physician and prince the funeral director, page 2 should be detached for use as the buriat-transit or the funeral director.	Certification: To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uniterlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a b. Due to (or as a d. Due to (or	consequence of): consequence of): consequence of): f pregnancy Fetal death 3 irre of death 5 t of resulting in the start resulting in the line of the line o	ent 3 DOA of 28c. Injury Work M 1 street, factory, office ath occurred at the tir investigation, in my of 29c. Licens	26. Place of left 4 Nurs y at k? Yes 2 No	23e. Did to 1 24a. Was autor perfo 1 Ves f Death (Check only or ing Home 5 Resid 28d. Describe for City or Tov	23d. Daty signe	ate of delivery onth Day Year Arribute to the cause of death? Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No her (Specify) rred there or Rural Route Number, thanner as stated, and due to the cause(s) ed (Month, Day, Year)
Vital Records, P.O. Box 68760,	Hospital or Attanding Physician: The law requires that the death certificate be executed to a hours after death. Funeral Director: After this certificate has been signed by the attending physician and prince the funeral director. After this certificate has been signed by the attending physician and prince the funeral director, page 2 should be detached for use as the buriat-transit or the funeral director.	Medical Certification: To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uniterlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a b. Due to (or as a d. Due to (or	consequence of): consequence of): consequence of): f pregnancy Fetal death 3 irre of death 5 t of resulting in the start resulting in the line of the line o	ent 3 DOA Other (specify) ent 3 DOA Other (work) of 28c. Injury M 1 Street, factory, office ath occurred at the tir investigation, in my of the course o	26. Place of left 4 Nurs y at k? Yes 2 No	23e. Did to 1 1 24a. Was autoperfor 1 1 Yes f Death (Check only of 28d. Describe to 28f. Location (Society or Town) 28f. Location (society or Town) 28f. Location (society or Town) 28f. Location (society or Town) 28f. Location (society or Town) 28f. Location (society or Town) 28f. Location (society or Town)	23d. Daty signe	ate of delivery onth Day Year Arribute to the cause of death? Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No her (Specify) rred there or Rural Route Number, thanner as stated, and due to the cause(s) ed (Month, Day, Year)

		_	For State Registra MFND ITFM #200	ate of Maryland PER FH C84					Reg. No.2 () ()	5 2524
	Physici		THELMA			SCHRO	EDER	Lugur	Day Y	ear 10:00-AM
	/Medic Examin		4a. Facility Name (If not institution, give stree KESWICK NURSING HOM			4b. City, Town, or BALTIM	r Location of Deatl		4c. County of	N/A
	Funeral Director		5. Social Security Number 220-48-7558 6. Sex Usual Residence of Decedent	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl Month, Day 07/03/	1907	B. Birthplace (State or Foreign Country) MD
	or death with the Maryland Items 23e or 28e-f show Per rust be notified at	Director	10a. State 10b. County N/A		y, Town or Lo	RE			40	10d. Inside City Limits 1 √ Yes 2 □ No
	with the	Dire	10e. Street and Number 700 W. 40th STREE	Т		10f. Zip Code 21211			10g. Citizen of Wh	
036	72 hours after death with the Maryland "neturel", or Items 23a or 28e-f show alcal Exarchinetr ast be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married	Vas Decedent Ever in U. Immed Forces? Yes 2 M No 1 Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cube	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		American Indian, White, etc. WHITE
21215-0036	within 72 ene. than "ne ne Medic	Completed	15. Decedent's Educatio (Specify only highest grade core Elementary/Secondary (0-12)	n npleted) College (1-4or 5+)	(Give life. I	dent's Usual Occup kind of work done of DO NOT use retired USEWIFE	during most of wor	king	16b. Kind of Busi	,
Maryland 2	ould be filed Mental Hygi arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last) UNOBTAINABLE				UNOBTA	NABLE	Maiden Sumame)	
	d 2 sho h and 7 is m treum		19a. Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's Name/Relationship (<i>Type</i> , Informant's N		1800 SARAS	BEN FRANI	KLIN DRIV 34236	TE APT.	r, City or Town, St A 301	ate, Zip Code)
Baltimore,	nit. Pages 1 and hartment of Healt ortent: If item 2 injury or other @.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo ^4 ☐ Donation 5 ☐ Other (Specify)	20b. P	lace of Dispo emetery, crer	sition (Name of natory or other place HEBREW	ca)	Date 02/2005	BALTTMOR REISTERS	Kor Town, State
Balt	permit. Departm Importe any inju		21. Signature of Funeral Service Licentee	utter		. Name and Addres	3(SON & BRO PIKESVILL	OS., INC. E, MD 21208
68760,	Physician //Medical Examiner	icai Examiner	23a. Part1. Enter the disease, or complicatic shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	use on each line.	ge de Juence of): Meseul Juence of):	er the mode of dyin		or respiratory ar	rest,	Approximate Interval Between Onset and Death Syeaks
.O. Box 68	death certific e attending pl ed for use as t	Physician/Medi	in the past 12 months?	f yes, outcome of pregna 1⊆Live birth 2 □ Fetal 4□ Pregnant at time of de 9□ Unknown	Ideath 3□	Ectopic pregnancy Other (specify)	′	20.	23d. Date Month	
Q .	es tha igned be de	by	Part II. Other significant conditions contributions	uting to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	70	ute to the cause of death?
l Records,	The law requir ate has been si page 2 should	Completed	ν					24a. Was autop perfor 1 \sum Yes	rmed? de:	ere autopsy findings available or to completion of cause of ath?] Yes 2 No
Vital	Physicien: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	ital:		Oth	4	ath (Check only o		
o	ling After fune	ation: To	1 Yes 20 No 1039 27. Manner of eath 2 1 CNdtural 5 Pending 2 Accident investigation	8a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor			fence 6 Other	
Division	el or Attendir s after death. I Director: Al d in by the fu	Certification:	3 Suicide 6 Could not be determined 2	8e. Place of Injury - At he building, etc. (Specify	ome, farm, str y)	eet, factory, office		28f. Location (S City or Tow		or Rural Route Number,
	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	Medical C	(Check only 2/ Medical Exeminer:	n: To the best of my kno On the basis of examina and manner stated.						
	To the To the comp	Ň	29b. Signature and title of certifier M. Kulelle Maa	Great Vi		29c. Licens	657		29d. Date signed (Month, Day, Year)
	1		20 Name and address of person who comple	eted cause of death (Item	1 23a) (Type,	Print)			,	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) AUG 0 3 2005	32. Registrar's Signa	dos	E .				

			Please 1	Type or Print in Black I	ndelible Ink. Ensure Ali	l Copies Are Legible				
		•	For State Registrar	,	partment of Health and Mertificate of Death	ental Hygiene	25242			
	° Physici	an	1. Decedent's Name (First, Middle, Las Donnie Thoma			2. Date of Death Month Day Yea	- VIVI DIM			
	/Medic	al	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death	JULY 13 20-	-3			
	Examin	er	SINAI HOSPITAL O		RALTIMORE CITY					
	Funeral Director		5. Social Security Number 6. Se		y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month, Day, Year)	irthplace (State or Foreign Country) Maryland			
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits			
	Ba-f sho	ector	Maryland N/A	Balt	imore	40 Civina d Millian	Yes 2 No			
	th with the 23s or 2 and 1st be m	al Dire	10e. Street and Number 5328 Cordelia	Avenue	10f. Zip Code 21215	10g. Citizen of What (Country?			
336	n 72 hours after death with the Marylar "naturel", or Items 23e or 28e-f show odical Exar direct one Descriptified at	by Funer	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ ₩ ivorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 1970 — If Yes, Give Year or Dates: 1971	8. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes	acity Yes or No-Rican, etc.) 14. Race - Ar Black, WI Specify: E	_			
21215-0036	withir ane. then	Completed by Funeral Director	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	de completed) (Given life. College (1-4or 5+)	sedent's Usual Occupation re kind of work done during most of workir DONOT use retired)	Johns Hop Universit	kins			
	be filed ntal Hygi od other event. I	To Be Co	12th grade 17. Father's Name (First, Middle, Last) Willie June Th		18. Mother's Name	(First, Middle, Maiden Sumame) Mae Gibbs				
Maryland	s 1 and 2 should be f f Health and Mental H item 27 is marked of other treumetic eve		19a. Informant's Name/Relationship (7 Jordy Thomas/ s	Type, Print) 19b. Ma 5 2 1 9	iling Address (Street and Number or Rura Cuthert Avenue	Route Number, City or Town, State Baltimore, Ma	. Zip Code) 21215 ryland			
Baltimore,	Pages 1 and 3 nent of Health int: if item 27 iry or other tr		20a. Method of Disposition Semetary 20b. Place of Disposition (Name of cemetery, crematory or other place) 8 / 2 / 05							
Balti	permit. Pages 1 Department of H Importent: If ite eny injury or ot once.		21. Signature of Funeral Services Licen	see	22. Name and Address of Facility Cha 240 Reisterstown		neral Home Md 21215			
			23a. Parti. Enter the disease, or compositock, or heaft failure. List only of	olications that caused the death. Do not e	nter the mode of dying, such as cardiac o	r respiratory arrest,	Approximate Interval Between Onset and Death			
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. CRYPTOCOCCAL MEN Due to (or as a consequence of):			1 WEEK			
	Examiner		Sequentially list conditions,	h SEPSIS			2 MONTHS			
16	cuted nd ransit	amine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence or).	NECROTIZING FASCITTIS	MAR THYLD SHT A				
68760,		Ĕ	resulting in death) Last	Due to (or as a consequence of):						
89 x	leath certificate t attending physic I for use as the b	/Medi	IF FEMALE:	23c. If yes, outcome of pregnancy		23d. Date of d	elivery			
O. Box	ne c the	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		B □ Ectopic pregnancy □ Other (specify)	Month	Day Year			
Δ.	res that the igned by be detact		Part II. Other significant conditions of	ontributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute				
ord	w require been sig should b	ted	HEPATITIS C			1 ☐ Yes 2 ☐ No 3, ☐	Probably 4 Unknown			
I Records,		Completed by	ATRIAL FIGRILLA	TION		24a. Was an autopsy performed? 1 Yes 2 No 1 Yes				
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	26. Place of Death					
of	Phys r this ral dii	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury 28b. Time	BILL 3 DOA 4 NOISING HOL	me 5 Residence 6 Other (S) 28d. Describe how injury occurred	pecify)			
Division	Attending F r death. sctor: After by the funer	cation	1. ■ Natural 5 ☐ Pending investigation	(Month, Day Year) Injury	M 1 ☐ Yes 2 ☐ No		O - 1 Posts M - tas			
Divi	2 th 15 c	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Street and Number or City or Town, State)	Hural Houte Number,			
	Hog Tur ely	Medical (ysician: To the best of my knowledge, de niner: On the basis of examination and/or and manner stated.						
	To the within 2 To the complet	Me	29b. Signature and title of certifier	200	29c. License number	29d. Date signed (Mo	nth, Day, Year)			

Registrar
DHMH 17 Rev 1/2001

State

SINAI HOSPITAL CO BALTIMORE

3 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)
AUG 0 3 2005

RES- pop

JULY Z3

2005

D			1 - State Unpend Item	State of Maryland 23a,pt.II,27,2	d / Departm 8a-£ perfic	ent of Health and The G846 8-18-	Mental Hygi 05 tas	ene g. No. 2005	25213
	Physic /Medi		1. Decedent's Name (First, Middle, L.	ast)			2. Date of Death Month JULY		3. Time of Death 6:53P. M
7	Exami		4a. Facility Name (If not institution, gi			ity, Town, or Location of Dea	th	4c. County of Death	1
5200	Funeral Director		Social Security Number 6.	TATI Sex 7. Age (In yrs. la 1 1 M 2 F 43	ast birthday) If Ur	OWSON der 1 Year If Under 24 Hr. hs Days Hours Mir			nplace (State or Foreign untry)
D	Maryland -f show lind at	tor	10a. State 10b. County M.D. N/C		Town or Location				10d. Inside City Limits 1864 2 □ No
	with the Man s or 28a-f sh be notified	Direc	10e. Street and Number			Zip Code	10	g. Citizen of What Cou	untry?
99	within 72 hours after death with the Maryland ene. than "natural", or Itema 23e or 28a-f show i.a Modical Exemirer must be notified at	/ Funeral Director	2 AS bury Com 11. Marital Status 1 ☐ Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces?	If Yes,	210 30 peedent of Hispanic Origin? (ispecify Cuban, Mexican, Pue s 2☐No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Amer Black, White	
Maryland 21215-0036	72 hours "natural",	leted by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E (Specify only highest gr	If Yes, Give Year or Dates: / 98/- /3 ducation ade completed)	16a. Decedent's U	Isual Occupation	orking 1	Specify: B/0 6b. Kind of Business/l	ndustry
12121	e filed within at Hygiene. other than vent, the Ma	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	lite. DO NO	Tuse retired) 5 MANUGER		OPA LICK.	
yland	s 1 and 2 should be filed within if Health and Mental Hygiene. Itam 27 is marked other than other traumatic event, the M	To Be	17. Father's Name (First, Middle, Las.) GEUIGE VADEN			BE#4	me (First, Middle, M Bluc Emen	,	
	s 1 and 2 sh of Health and Itam 27 is m other traum		19a. Informant's Name/Relationship MARShu Vade.	J	2 ASbu	ess (Street and Number or R LN Cound BA Name of			
altimore,	permit. Pages I Department of I Importent: If Its eny injury or ot once.		20a. Method of Disposition 1 □8urial 2 □ Cremation 3 [4 □ Donation 5 □ Other (Speci		metery, crematory	Perme Hery S/			
Ball	Depart Depart Import eny in		21. Signature of Funeral Service Lice	UNI	1129	N. CATOLINE ST	BA Homore	NO 2121	3
	Physician /Medical		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Drowning	Do not enter the n	node of dying, such as cardia	c or respiratory arres	st,	Approximate Interval Between Onset and Death
8760,	ate be executed by sician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) d	ence of):				
Вох 6	Attending Physicien: The law requires that the death certific rideath. sctor: Atter this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea	leath 3□Ectopic	pregnancy (specify)		23d. Date of deliv Month	ery Day Year
rds, F	quires tha an signed ould be del	ed by P	Part II. Other significant conditions of Alcohol intoxicat		ting in the underlyin	g cause given in Part I.		cco use contribute to t	he cause of death?
Division of Vital Records, P.O.	ician: The law re certificate has be ector, page 2 sho		25. Was case referred to medical					prior to co death?	opsy findings available impletion of cause of
of Vit	Physicia this cert	To Be	examiner? 1 X Yes 2 □ No		R/Outpatient 3	DOA Other: 4 Nursing H	ath Check only one lome 5 Residen	ce 6 ⊡Other (Speci	(y)
ion	Attending F death. ctor: After y the funer	atlon:	27. Manner of Death 1 □ Natural 5 □ Pending 2 ★ Accident investigatio	7-2'9°0'5 ^{ay Year)} 6	28b. Time of Cound D	28c. Injury at Work? 1 ☐ Yes 2X No	28d. Describe how subject	injury occurred	
Divis	Diriginal of the control of the cont	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify) residence		ory, affice	28f. Location (Stre City or Town, Cockeysv	et and Number or Ryr State) 2 Amesb ille, Mary	al Route Number, ury Court Land
	To the Hospital within 24 hours a to the Funeral I completely filled	edical	29a. Certifier (Grack only one)	ysicien: To the best of my knowl illier. On the basis or examination and manner stated.	edge, death occurrent and/or investigati	ed at the time, date and place on, in my opinion, death occu	and due to the cau	co/c) and manner ac	tated
	To the within To the comp	Me	29b. Signature and title of certifier	11-11	2	29c. License number	29d	. Date signed (Month,	Day, Year)
j),	Kyon		30. Name and address of person who		23a) (Type, Print)	O.C.M.E.	JU	LY 30, 200	5
	Sta	te	TACK M, -	32. Pogistrar's Signatu	111	PENN STREET,	BALTIMORE	MARYLAND 2	1201
	Registr		AUG 0 3 2	32. Figistrar's Signatu	1 Love	2			

State of Maryland / Department of Health and Mental Hygiens 0 0 5 25244 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Geneva B. Will 4:15 A.M Ju₁y 2005 /Medical 31 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 4746 Woodbine Road Carroll Sykesville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 19, 1 Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 M 2 X F 81 219-58-4953 Yrs Director Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ehow 10d. Inside City Limits treumetic event, the Medical Examinations be notified at Maryland Director Carroll Sykesville 1 Yes 2 No 28e-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Iteme 23e or 4746 Woodbine Road 21784 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 X Widowed 4 ☐ Divorced naturel Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 3rd Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 shoutd be fi and Mental H ie marked of Lee Hipkins Pages 1 and 2 should Florence Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 ie any injury or other treu once. Michael Shifflett grandson 5115 Wards Chapel Road Owings Mills, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Lake View Mem. Park |Aug. 3, 2005 Sykesville, Maryland 22. Name and Address of Facility
Burrier-Queen Funeral Home & Crematory, PA 21. Signature of Funeral Service Licens anny 1212 W. Öld Liberty Road Winfield, MD 21784 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each me. Approximate Interval Between Onset and Death In ediate Cause (Final disease or condition resulting in death) MALNUTRITION Physician 2 MONTHS /Medical Due to (or as a consequence of): Examiner DEPRESSION Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 6monTH) Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Box 68760. by Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Petal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Year Month Day 4☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ed bluods 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s of Vital 1□ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physicien: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of after death. 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funerel [Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) DO059551 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 GOURISHANKAR 700 A POULE RD WESTMINSTER NAGANNA 32. Fe gistrar's Signature 31. Date filed (Month, Day, Year) AUG - 3 State 2005 Registrar

			For Stata Registrar	State of Marylan		ent of Hea ate of De			2005	25245
	Physicia		1. Decedent's Name (First, Middle, La	silla Ma	1100 1	115/1		2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)	4b. C	ity, Town, or Lo	ocation of Death	y co	4c. County of Dea	
	Funeral		5. Social Security Number 6.5	ins HOSIYA	last birthday) If Un	der Year II	1 Under 24 Hrs.	8. Date of Birth (Month, Day, Ye		N/A rthplace (State or Foreign
	Funeral Director			□M 2√x F 73	Yrs. Mont	ns Days I	Hours Min.	(Month, Day, Ye May 15.		Country)
	pur *		Usual Residence of Decedent 10a. State 10b. County	10e Cit	ty, Town or Location					10d. Inside City Limits
,	Maryla 1 sho	ō			Washingto	n				1 No 2 No
Ĭ,	r 28a	irect	10e. Street and Number		10f.	Zip Code		10g.	. Citizen of What C	Country?
	th with	al D	3209 W. Street	South East		200	20			USA
9	permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department: If term 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3XXVidowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			anic Origin? (Spec Mexican, Puerto F Specity:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
	2 hou atural		15. Decedent's E	ducation	16a. Decedent's t	Isual Occupation	on	160	b. Kind of Busines	s/Industry
7	thin 7.	Completed	(Specify only highest grant Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	work done duri T use retired)	ing most of workin	g		
7	iled wi tygien her th		12 17. Father's Name (First, Middle, Last	5+	So		rincipal	(First, Middle, Mai	Educatio	nn
2	d be fi	o Be	Isaiah Malloy	,			b. Mother's Hame		a Moore	
2	2 should be filed with and Mental Hygiene, is marked other that aumatic event, the M	Ĕ	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Add	ess (Street and	d Number or Rural	Route Number, C	ity or Town, State,	Zip Code)
Ě	and 2 salth a n 27 is		Sharon Green / 1						eake VA 2	
Dalillione	permit. Pages 1 and. Department of Health Important: If Item 27 any injury or other tr once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specia	Removal from State Ho	Place of Disposition (cometery, crematory) Opewell UN	or other place) IC Ceme1	tery 08/0		Tatus,	
Dall	permit. Departi Import. any inj		21. Signature of Funeral Service Lice	8	da, Jrz. Name Cha 150	Ties L	. Stevens ort Aveni	s Funeral Le, Balti	Home, I	nc 21230
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	pplications that caused the deat one cause on each line.	th. Do not enter the r	node of dying,	such as cardiac or	respiratory arrest		Approximate Interval Between Onset and Death
F	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. CANCOK-	Unknow	V PAIN	MARY			4 months
	Examiner		1	Chall hour	UNKNOW/ quence of): 1El Obs	terret.	00)			24/ppks
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	Due to (or as a consequence of):					
	acuted ind transi	Examin	Cause (Disease or injury that initiated events resulting in death) Last	· Cholangin	tis					2 WEEKS
00/00	icate be executed physician and s the burial-transit	icai Ex	Tosaining in additity cast	Due to (or as a conseq	quence oi);					
	ficate g phys is the	P	`	d						
O. DOX	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	al death 3 □Ectopi	c pregnancy (specify)			23d. Date of de Month	elivery Day Year
ŗ.	that the by detact		Part II. Other significant conditions	,	-,	ng cause given	in Part I.	23e. Did tobac	co use contribute	to the cause of death?
corus,	w requires been sign should be	ed by	CONGESTIVE HE	ART FAILUR	25			1 🗆 Yes	2 /2 No 3□F	Probably 4 Dunknown
202	e law requ has been je 2 should	Completed	Poor Nutrit	ion				24a. Was an autopsy	prior te	autopsy findings available completion of cause of
	n: Th ficate or, pag	e Co	25. Was case referred to medical				IC Place of Poeth	1 Tes 2	No 1/2 Ye	s 2 No
VII	Physician: r this certific ral director,	OB	examiner?	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other:	6. Place of Death 4 ☐ Nursing Horr		e 6 □Other (Sp	ecify)
SION OF	Attending Physic death. ector: After this by the funeral di	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		8d. Describe how		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be determined		ome, farm, street, fac fy)					Rural Route Number,
	o the Hospital or vithin 24 hours after o the Funeral Dir ompletely filled in I	edical (hysician: To the best of my knominar: On the basis of examination and manner stated.						
	To t To tl	M	29b. Signature and title of cerufier	000.		29c. License n	number	29d.	Date signed (Mor	nth, Day, Year)
_		5	- Secure to	elle, mr)	DOO	01391	Ac	1615+ 1	2005
4	11.		30. Name and address of person who	completed cause of death (Item	m 23a) (Type, Print)	Ch. A	11 - none	e, Mayr	but o	1284
-	Sta	ate	31. Date filed (Month, Day, (947)	3 2003. Registra s Sign	ature 10. Poly	141/	STIF VIOL	er Timed &	THE DI	23/
	Regist		Hou 0	O LOUIS NOON						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 28, 6:31 A 2005 PEGGY WEBB July RAE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Edward W. McCready Memorial Hospital Crisfield Somerset If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) November 8, 1929 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5 Social Security Number 6. Sex **Funeral** Hours 1 ☐ M 2 🗓 F Months Days 75 Director Maryland 215-26-5017 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 te marked other than "neturel", or Items 23e or 28e-1 show other treumatic event, the Machael Examination using the invitibal at 1 ☐ Yes 2 ☑ No Director Maryland Somerset Westover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21871 8859 Crisfield Highway USA Completed by Funeral iled within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Worker Seafood 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be Katie Sterling 2 Columbus Morgan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 I 302 South Memorial Drive - Delmar, Maryland 21875 Weldon Lawson, Jr. (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 0 = 0 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important; If `4 □Donation 5 ♥ Other (Specify) Entandment 8/01/05 Westover, Maryland injury Family Mausoleum 21. Signature of Funeral Service Licensee Mary Both Bradshaw-Pruitt Bradshaw & Sons Funeral Home 'n 306 W. Main Street - Cristield, Maryland 21817 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) rore CANDIUMScallan **Physician** mony /Medical years Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) attending physician Completed by Physician/Medical the IF FEMALE: esn If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day Year in the past 12 months? 1 \(\subseteq\) Yes 2 \(\subsetex\)XNo 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by t i be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed 2 XNo 1 Yes 2 10 Physicien: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2X ER/Outpatient 3☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2XNo Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After or Attending 1 XNatural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 Homicide To the Hospitel owithin 24 hours aff To the Funerel Dicompletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 37817 July 29, 2005 -1008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Baltimore, Maryland 21215-0036

P.O.

Division of Vital Records,

DHMH 17 Rev 1/2001

How & Joseph ORIGINAL

32. Recistrar's Signature

AUG 0 3 2005

31. Date filed (Month,

Michael Atkins, M.D. - 201 Hall Highway - Crisfield, Maryland 21817

			partment of Health and Ment ertificate of Death	al Hygien	e	05017			
Physic /Medi		1. Decedent's Name (First, Middle, Last) (JE55 B. WILLA	N.A.	ate of Death	2005 8, 2005	1:00 P. M			
Exami		4a. Facility Name (If not institution, give street and number) 3214 BAYONNE AVE	4b. City, Town, or Location of Death BALTIMORE	4	c. County of Death	12100 22			
Funeral Director		5. Social Security Number 6. Sex 1 1 1 M 2 □ F 7. Age (In yrs. last birthda) Yrs. Usual Residence of Decedent	Months Dave Hours Min (A	ate of Birth fonth, Day, Year ENUFIC 30,	9. Birth Cou 1948 MA	place (State or Foreign ntry) CYLAHD			
ne Maryian 8e-f ehow zilling at	ector	10a. State 10b. County 10c. City, Town or I BALTINO				10d. Inside City Limits 1			
eath with ti	Funeral Director	10e. Sfreet and Number 32/4 BAYONNE AVE. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Marital Status	10f. Zip Code 2/2/4	i	itizen of What Cou				
ours after de reit, or item	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 🕏 No Specify:	es or No- , etc.)	14. Race - Ameri Black, White, Specify: WH	etc.			
within 72 ho	Completed	(Specify only highest grade completed) (Giv Elementary(Secondary (0·12) College (1·4or 5+)	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)		b. Kind of Business/Industry				
ges 1 and 2 should be filed within 72 hours after death with the Maryland ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other then "naturel", or items 23a or 28s-1 show or other traumatic event, the Modical Examinar must be notified at	To Be Co	17. Father's Name (First, Middle, Last) BERKELEY F. WILLARD	A BORFIZ 18. Mother's Name (First MAMIE WOO	t, Middle, Maide	9R WASH n Sumame)				
0 0 = 0		19a. Informant's Name/R ationship (Type, Print) LINDA R. WILLARD SISTER 1010	ing Address (Street and Number or Rural Rould B WOOLAKE INVE ATT-B (2	te Number, City					
Pa men ant: ury			nosition (Name of place) Date of penatory or other place) REMATORY Solution (Name of place) REMATORY Solution (Name of place)						
permit. Departimont		21. Signature of Funeral Service Licensee Muchael Marguelo 23a. Part 1. Enter the disease, or complications that caused the death. Do not en	009 HARFORD ROAD BALT	MORE. MA	RYLAHO	103			
Physician /Medical Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	of and a variable of a variable of responsible of the cardial variable of the cardial variable of the cardial variable of the cardial of the cardial variable of the cardial variable of the cardial of the cardial variable o	Di	scare	Approximate Interval Between Onset and Death			
cate be executed physicien and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):							
tificate being physicie as the burn	dicai								
The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year			
w requires that been signed be should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the	o use contribute to the cause of death? 2 No 3 Probably						
ician: The law r certilicate has be rector, page 2 sh	Completed		2.	4a. Was an autopsy performed? Yes 2 ☐ N	prior to co death?	psy findings available mpletion of cause of 2 No			
or Attending. Physicien: The lifer death. Director: After this certificate his in by the funeral director, page	To Be	25. Was case referred to medical examiner? 1			6 ∰ther (Specif	y) SCENE			
ath. or: After	ation:	27. Manner of Death Satural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury (Month, Day Year)	of 28c. Injury at Work? M 1 Yes 2 No	escribe how inju	ury occurred				
To the Hospitel or Attending Physicien: within 24 hours effer death. To the Funerel Director: After this certifical completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	Ci	ity or Town, Star					
To the Hospitel within 24 hours To the Funeral completely filled	Medical	29a. Certifier (Check only 2 X Madical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and du nvestigation, in my opinion, death occurred at the	e to the cause(he time, date ar	s) and manner as s nd place, and due to	tated. the cause(s)			
To with	2	29b. Signature and title of certifier	29c. License number O.C.M.E.		29, 2005				
21		30. Name and address of person who completed cause of death (Item 23a) (Type J. 44600 Lower M)	Print) 111 PENN STREET BALT	IMORE,M	ARYLAND 2	21201			
St Regist	ate	31. Date filed (Month, Day, Year) AUG 0 3 2005	Localis						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			(Certificate of L	Death	R	leg. No. () () 5	25248
			1. Decedent's Name (First, Middle, Last)			Date of Deal Month	th Day Year	3. Time of Death
	Physicia /Medic		Teresa J. Anglin				26, 2005	1:35 PM
3	Examin		4a. Fecility Name (If not institution, give street and number)	4	lb. City, Town, or Loc	etion of Death	4c. County of Deatl	
			HCR-Manor Care Towson	If I Index 1 Voor	TOWSON If Under 24 Hrs.	O. Data of Birth	Baltimo	
	_c Funeral Director		137-12-0269	nday) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day Jan • 1	1922 Year)	hplace (State or Foreign untry) New Jersey
	Pu &		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location				10d. Inside City Limits
	Aaryle I sho	5	MD Baltimore Tows	on				1 ☐ Yes 2 💆 No
	28e-	Director	10e. Street and Number	10f. Zip Code		1	10g. Citizen of What Co	untry?
	with Se or		509 E. Joppa Road	21204			U.S.A.	
	ns 2%	Funeral	11 Marital Status 12. Was Decedent Ever in U,S.	13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe	cify Yes or No-	14. Race - Ame	
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "heturel", or items 23e or 28e-f show any injury or other treumatic event, The Medical Examination in ust be notified at once.	þ	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give 3 ☒ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 ☒ No		tican, etc.)		hite
2-0	72 ho	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	ation during most of workin	ng	16b. Kind of Business/	Industry
21	ithin i	ng n	Elementary/Secondary (0-12) College (1-4or 5+)		d)		Own Hom	0
21	ygien ygien her th			omemaker	18. Mother's Name	(First Middle		=
and	be fill	Be	17. Father's Name (First, Middle, Last)		Serafi			
ž	1 Mer narke	7	Michael Kopac 19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street				Zip Code)
Ma	d2 st th and 7 is n treur	Ì	Total Wilderhalt Strands of Control of Contr	9 Singer				
(a)	1 and Healt em 2		20h Place of	Disposition (Name of		Date	20c. Location - City or	
<u>0</u>	ages ant of t: If it y or c		1 ☐ Burial 2 XCremation 3 XRemoval from State YORK 4 ☐ Donation 5 ☐ Other (Specify)	towne tion Serv		ily 28,	York, P.	Α
Ħ	artme ortan injur	li	21 Separation of Furnance Society (Specially)	22. Name and Addres				rtuary, Inc.
ä	Ped lang	8	ames Horenauth	24 Secon	d St., N	lew Fre	edom, PA	17349
			23a, Part1. Enter the disease, or complications that caused the death. Do n					Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each line.					Onset and Death
	/Medical		Immediate Cause (Final disease or condition	RENA	- FAIL	-uR	E	
	Examiner		resulting in death) Due to (or as a c		- 32			
	ed sit	Examiner	b					
	ertificate be executed ling physician and e as the bunal-transit	xan	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditions are conditional conditional conditional conditional conditions are conditional conditional conditional conditional conditions are conditional conditi	onsequence of).				
9	be e sician buris		cause. Enter Underlying Cause (Disease or injury that initiated events	ancaguanaa of):				
68760,	ficate p phys	Medical	that initiated events resulting in death) Last Due to (or as a co	onsequence on.				
×	nding use a	2	d					
. Bo	death ce e attend od for us	Physician/	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause giv	en in Part I.	23b. Did t	tobacco usa contributa	to the cause of death?
P.0	t the by th tache	چُ				1 🗆 1	Yes 2☐No 3☐P	robably 4 Unknown
	es that the de igned by the a be detached t	by	11-17 612 1810 37 070 3 0010	003110	C		/	18/ to the say findings
Vital Records,	The faw requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the bunal-transit	te d	HEART FAILURE, ADVANCE	Es DEME	WTA	24a. Was perfo	rmed?	Were autopsy findings available prior to completion of cause
Ö	has be	Completed	TOTAL TOTAL		1		,	of death?
H	The sate has	S				101	res 2 No	1 ☐ Yes 2 ☑ No
Vita	ysicien: The s certificate director, pag	Be	25. Was case referred to medical examiner? Hospital:	Oth	26. Place of Death			
of	Physical this call directions	-T	1 ☐ Yes 2 ☐ No	tpatient 3LI DOA	4/CJ Nursing Hor		dence 6 Other (Spe	ciry)
L C	ding F h. After funer	tion	1 □Natural 5 □ Pending (Month, Day Yeer) Ir	njury Wor	rk? ∣Yes 2 □ No			
Division	or Attending Physicien: after death. Director: After this certific I in by the funeral director,	fica	3 ☐ Suicide 6 ☐ Could not be 28e, Place of Injury - At home, fai	rm, street, factory, office	- 2	28f. Location (S City or Tox	Street and Number or R	ural Route Number,
D.	ਨ ਵੱ ਂ ਵੋ.⊆	Certification:	4 ☐ Homicide determined building, etc. (Specify)			City of Ton	wii, State)	
	To the Hospital or Attent within 24 hours after deat! To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, (Check only one) Certifying Physician: To the best of my knowledge, and manner stated.	, death occurred at the tir For investigation, in my c	me, date and place, a opinion, death occurre	and due to the e	cause(s) and manner a date and place, and due	s stated. e to the cause(s)
	Vithin To th	Me	29b. Signature and title of certifier	29c. Licens	se number		29d. Date signed (Mon	h, Day, Year)
			Velaller them mo	Di	23450		7/26/0	5
			30. Name and eddress of person who empleted cause of death (Item 23a) (Type, Print) -VOE, JOF	- 0		1 3 13	0/-
_	5		WALTER HEPNER MD 12		PAKO	1000	son LIL	-00
4	Sta		31. Date filed (Month, Day, Year) AUG 0 3 2005	Coole				

			1 - For State Registrar	State of	Maryland / De	partment ertificate			ental H		_	
			Decedent's Name (First, Middle, L.)	ast)		071770010	0, 50		2. Date of D	Reg. No Death	CUU3-	2. Time of shath
	Physici /Medi		Juanita Virginia	ABLE					July	22,	^{ay} 2005 Year	3:20 am M
	Examir		4a. Facility Name (If not institution, g		ber)	4b. City, To	own, or Loc	cation of Death			c. County of Death	
		Ų.	Reeders Memorial				nsbor				ashingto	
010	Funeral Director		5. Social Security Number 6. 215-14-1081 Usual Residence of Decedent	Sex 7 1 ☐ M 2 X F	7. Age (In yrs. last birthda 85	Months		lours Min.		Day, Year	9. Birth Cou 1919 Mar	plece (State or Foreign intry) yland
5	show		10a. State 10b. County		10c. City, Town or	Location						10d. Inside City Limits
7	death with the Maryland ms 23e or 28e-f show Franst be notified at	ţċ	Maryland Washin	gton	Hage	erstown					į	1 ☐ Yes 🌠 ☐ No
\supset	th the	Director	10e. Street and Number			10f. Zip C	ode			10g. C	itizen of What Cou	intry?
	ath wi		1353 Outer Drive				1742				U.S.A.	
2	er des	Funeral	11. Marital Status	Armed Ford	lent Ever in U.S. 1	Was Deceder If Yes, specify	nt of Hispa y Cuban, N	nic Origin? (Spe lexican, Puerto I	cify Yes or N Rican, etc.)	No-	 Race - Ameri Black, White 	
uanita 5-0036	If Z 12.13-0030 filed within 72 hours after death with the Maryla Hygiene. ther then "neturel", or Items 23e or 28e-f show int, the Medical Evantiner must be notified at	by	1 ☐ Never Married 2 📉 Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 3 If Yes, Give Year or Dai		1 ☐ Yes 2	No S	pecify:			Specify: W	hite
Juani	be filed within 72 hattal Hygiene. Id other then "netu	Completed	15. Decedent's l (Specify only highest g Elementary/Secondary (0-12)		(G.	cedent's Usual (ive kind of work b. DO NOT use	Occupation done durin retired)	n ng most of workir	ng	16b. I	Kind of Business/tr	ndustry
ر , الا	ed will ygien t. Ins	Con	12	0		ivitor					craft Mf	g
() E	ed its p	Be	17. Father's Name (First, Middle, Las	st)			18.	Mother's Name	(First, Midd	le, Maidei	n Sumame)	
	hould hould d Mer marke matic	10	Charles Mayhugh 19a. Informant's Name/Relationship	(Tuna Brint)	105 14	siling Address (Susan Mu				- 0-1-1
+ble,	d 2 st d 2 st th and 17 le n treun					4650 75					or Town, State, Zij	
me: A	C = M =		Edward W. ABle — 20a. Method of Disposition 1X Burial 2 □ Cremation 3		20b. Place of Dis	Duter sposition (Name trematory or other	of	e, Hager	rstown ate	20c. L	ryland 2 ocation - City or T	1740 own, State
0	men men lent:		*4 ☐ Donation 5 ☐ Other (Spec	city)	Cedar L	awn Mem.	. Par	k 7/26	/05	Hag	erstown,	Maryland
a me	permit Dopar Import any in		21. Signature of Funeral Service Lice	D-							ral Home	217/0
\rightarrow			23a. Part1. Enter the disease, or co	molications that car							wn, Md.	21740 Approximate
0	Physician /Medical		shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	y one cause on ea	Preym		, ,		,		4	Interval Between Onset and Death
7.0	Examiner		1	Due to (o	r as a consequence of):	cers e	No in	anlia	-			: MON
		-e	Sequentially list conditions, if any, leading to immediate	b. Due to (o	r as a consequence of):	WI O	JCII)	enua				90483
	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C	,							
_	an an	Exa	resulting in death) Last	Due to (o	r as a consequence of):							
8760	cate be executed physician and the burial-transit	dlcal	•	d								
Œ		a a	IF FEMALE:	00 1/								
B V	eath certifi attending	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live bin		3 □Ectopic preg				1	23d. Date of deliv- Month	ery Day Year
	by the a	ysic	1 □ Yes 2 No 9 □ Unknown	4∟Pregnai 9□ Unknov		5 ☐ Other (spec	:rfy)					•
٥	Attending Physicien: The law requires that the death certifind death. sector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	by	Part II. Other significant conditions	contributing to dea	th but not resulting in the	underlying cau	se given in	Part I.	1			the cause of death?
2	require been signature	eted		0,00							□No 3 □ Prot	. , , ,
Bec	The taw	Completed			·				24a. Wa aut per 1 Yes	opsy formed?	prior to co	opsy findings available impletion of cause of
ita eti/	vicien: Th	Be	25. Was case referred to medical examiner?	Haspital:				Place of Death			-	
ţ	Physi this c	To.	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 In	patient 2 ER/Outpat						6 Other (Special	(y)
5	ding F h. After funer	tion	1 Matural 5 ☐ Pending	(Month,	Day Year) Injur	y M	. Injury at Work?	2 🗆 No	8d. Describe	a now inju	iry occurred	
Olivicion of Vital Records P O	or Attendition or Attendition of the finish the finish the finish the finish or the finish the finish or the finis	Certification:	2 Accident Investigate 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place o	of Injury - At home, farm, g, etc. (Specify)				8f. Location City or To	(Street a	nd Number or Rura e)	al Route Number.
<u>.</u>	Hospite 4 hours Funerel	edical Ce	(Check only 2 Medical Exe	eminer: On the bas	est of my knowledge, de	eath occurred at investigation, in	the time, d	late and place, a	nd due to the	e cause(s	i) and manner as s	stated. o the cause(s)
	To the P within 24 To the F complete	Med	one) 29b. Signature and title of pertifier	and manne	or stated.		icense nu				ite signed (Month,	
	. 0		255. Signature and three destines	12			0 44			Je	-	2005
	AB,		30. Name and address of person who					01710	201	420		
	Sta	ate.	31. Date filed (Month, Day, Year)	20311 Laj	ppans Rd. B	oonsbor	o, MD	21/13	301-	432-	04/0	
	Regist		JUL 25	2005	alexa H. s	Coertes						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.2 0 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year DONALD LEROY ALBERT JULY 9:35 P M 14, 2005 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death LORIEN NURSING HOME TANEYTOWN CARROLL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) **™** M 2□ F Yrs. Director 168-18-4808 83 6/18/1922 Pennsylvania Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "neturel", or Items 23a or 28e-f show other treumatic event, the Madical Examination as PΔ BUCKS LEVITTOWN Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 VALLEY RD. 19057 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: WWII 1 ☐ Yes 2 🗷 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR 12 GOVERNMENT permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked othe any injury or other treumatic event, since 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MELVIN ALBERT FLOSSIE ပ BONNEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETTY ANN ALBERT 11 VALLEY RD., LEVITTOWN PA., 19057 - WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State COUNTY CREMATION 7/15/05 4 ☐ Donation 5 ☐ Other (Specify) SYKESVILLE, MD 22. Name and Address of Facility FLETCHER FUNERAL HOME 21. Signature of Funeral Service Licensee 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician METASTATIC SARCOMA disease or condition resulting in death) 6 mos /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause principle, that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: esn. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? be detached for Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 12memia eted 1 Yes 2 No 3 Probably 4 Unknown AWASARLA 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐No autopsy performed? Dofficile دن ارنگ C 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending within 24 hours after death.

To the Funerel Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 / Homicide Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Wir D43643 7-15-05 STIVA ANE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m.D. 21787 TANEY TOWN. WD A. conus/ Dr. Tason 32. Registrar's Signature 31. Date filed (Month, Day, Year) Glew & fraile Registrar

			State of Maryland / Department of Health and N 1- State registrar Certificate of Death	-	giene	25251					
	Physici /Medic		MADELINE CICCARELLI BYNUM	2. Date of Dea Month JULY	Day Year 26, 2005	3:00A M					
	Examin Funeral Director	er	GENISES ELDERCARE LAPLATA CENTER LA PLATA 5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) 1 Months Days Hours Min.	8. Date of Birt (Month, Da		RLES inthplace (State or Foreign Country)					
	ū	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	MAY Z	0,1925 WF	ASH., DC 10d. Inside City Limits 1 ☑ Yes 2 □ No					
	with the Nance 28e-	Dire			10g. Citizen of What C						
36	hours after death with the Maryland turel', or Itams 23a or 28e-f show at Examiltarinust be rediffed at	by Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes, specify Cuban, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race - Am Black, Wh	nerican Indian,					
21215-0036	d within 72 giene. rrthan "nai	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 15. Decedent's Usual Occupation (Give kind of work done during most of work) (ifte. DO NOT use retired) TITLE CLERK	ing	16b. Kind of Busines DEPT. OF	MOTOR					
Maryland	should be filed nd Mental Hygid a marked other umetic evant, II	To Be C	17. Father's Name (First, Middle, Last) CHRISTOPHER CICCARELLI JOSEPH JOSEPH	HINE C	Maiden Surname) APPAROTTA						
	1 and 2 Health a am 27 le ther tra		19a. Informant's Name/Relationship (<i>Type, Print</i>) MARIA SCHLINE-WATSON-DAUGHTER 17207 MANNING I 20a. Method of Disposition 20b. Place of Disposition (<i>Name of</i>			K,MD 20607					
Baltimore,	permit. Pages Department of Importent: If it any injury or o		1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) METROPOLITIAN CREMATORY 7- 21. Signature of Funeral Service Licensee MO0479 22. Name and Address of Facility	-28-200		IDRIA, VA					
	Physician /Medical Examiner	ıysician/Medicai Examiner	edicai	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):		9646 Post, 46	Approximate Interval Between Onset and Death				
8760, <	ate be executed hysician and the burial-transit			edicai				sequentially list continuous, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
.O. Box 6	death certific e attending p id for use as t							23d. Date of d	elivery Day Year		
rds, P	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute (es 2 🗆 No 3 🗆 F	to the cause of death? Probably 4 Minknown					
Vital Records,	The ate ha	Completed		1 ☐ Yes	prior to death? 2 \(\frac{1}{2} \) Ye	autopsy findings available completion of cause of es 2 \sum No					
Division of Vit	ttanding Physician: Tdeath. ctor: After this certifica y the funeral director, p	To Be	To B	examiner? 1 Yes 2 No	me 5 Resid	ne) dence 6 □Other (Sp now injury occurred	ecify)				
Divis	Hospital or Attanding 14 hours after death. Funaral Diractor: Afte tely filled in by the fune	i Certification;		City or Tow	,						
	To the Hospital or At within 24 hours after or To tha Funaral Diract completely filled in by	Medical	29a. Certifler (Check only one) 29a. Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, consider the time of the time, date and place, consider the time of the time, date and place, consider the time of the time, date and place, consider the time, date an	ed at the time, o	cause(s) and manner a date and place, and du 29d. Date signed (Mor	ie to the cause(s) -					
)	,- ,- 0		30. e nd address prison who completed cause of death (Item 23a) (Type, Print)	24	712	7175					
	5 Sta Registr		■	ワクの	r, mil	20102					
	negisti	ar	Julieur Jr. Marie			,					

					Cert	ificate of	Death	R	eg. No2 0	05	25252
	Dhysia		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th	Vace	3. Time of Death
	Physic /Medi		Mabel Elizabeth	Bridgett				July	17,	20°5	3:50PM
	Exami		4a. Facility Name (If not institution, give street and				4b. City, Town, or Lo	cation of Death	4c. County		
			Charles County Nu:	rsing Reh	nab C	enter	La Pla	ta		Char1	les
I	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In vrs. las	t birthday)	If Under 1 Year Months Days		imonth. Dav	Year) 9,1917	9. Birthpl Count M.a.	ace (State or Foreign try) ryland
	ō		Usual Residence of Decedent 10a. State 10b. County		Town or Loca	ation	Tebre	iary r.	,,1)17		Dd. Inside City Limits
	the Ma 28a-f	recto	MD Charles 10e. Street and Number	C	har1c	tte Ha	11		0g. Citizen of	What Count	1 ☐ Yes 💥 No
	ath with s 23a or nust be	Funeral Director	11600 Stines Store			206			US	A	
020	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other then "netural", or items 23a or 28a-f show imatic event, its Madical Examiner must be routlied at	ρ	1 Never Married 2 Married 1 Yes,	ecedent Ever in U,S. Forces? es 2 No Give r Dates:		as Decedent of I Yes, specify Cub ☐ Yes 2ሺ No	Hispanic Origin? (Spe an, Mexicen, Puerto Specify:	ecify Yes or No- Rican, etc.)		ce - America ck, White, e y: W	
0200-91212	hin 72 h J. In "netu Madical	Be Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) Colleg	e (1-4or 5+)	6a. Decede (Give ki life. DC	nt's Usual Occup nd of work done O NOT use retire	pation during most of worki d)	ng	16b. Kind of B	usiness/Ind	ustry
7	d with	E O	8	9 (1-401 57)		Homema	ker			Home	e
	illed w Hygiei other ti	O e	17. Father's Neme (First, Middle, Last)				18. Mother's Name	(First, Middle, I	Maiden Suman		
<u>ā</u>	ind be lenta ked ic ev	To B	G. Cleveland Herbe	rt			Mary El	izabet	h Gra	V	
Maryland	2 shot and is ma	F	19a. Informant's Name/Relationship (Type, Print) Charles Bridgett/S	on .	19b. Mailing	Address (Street	and Number or Rura	l Route Number	City or Town,	State, Zip (_{соф} 20622 На11 MD
ē,	s 1 and f Health frem 27 other t		20a. Method of Disposition	20b. Place		tion (Name of tory or other pla			20c. Location -		-
Ē	Page nent o int: if		Y Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)					//21/05	Char	lotte	e Hall,M
Baltimore,	permit. Pages 1 ar Department of Heal Important: if item 2 any injury or other once.		21. Signature of Funeral Service Licensee	hul	^{22.} A	REHART	ECHOLS	FUNERA	L HOM	E, P.	Α.
			23a. Part . Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the death. D			X 567, I			1	Approximate
تخمير	Physician /Medical Examiner	ner		Cadism Due to (or as			discip				Interval Between Onset and Death
	executed in and riel-transit	Examiner		Due to (or as			- 1.Joseff		-		
Ď,	be exercian a	a E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							i	
00/00 Y	centificate be executed nding physician and use as the buriel-transit	/Medical	that initiated events resulting in death) Last	Due to (or as	a conseque	nce of):					
0			Part II. Other significant conditions contributing to	dogth but not requition	a in the west	advisa saves siv	on in Bod I	nob Didao			
5	that the	y Physiciar	Cerebra vas cular			enying cause giv	en in Part I.		s 2 No		tha causa of deeth? ably 4 ☐ Unknown
SCOLUS,	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death within 124 hours after death and to the Euneral Director: After this certificate has been signed by the attencompletely filled in by the funeral director, page 2 should be detached for u	Completed by						24a. Was ar perform	autopsy led?	avail com	e autopsy findings able prior to pletion of cause eath?
ב ב	The I	E						1 ☐ Ye	s ZE No	1 🗆	Yes 2□ No
12	an: rtifica tor, p	Bec	25. Was case referred to medical	- Agents			26. Place of Death				
>	yslci s cer direc	70	examiner? 1 ☐ Yes 2 ☐XNo Hospital:	☐Inpatient 2☐ER/	Outpatient	3□ DOA Oth				ar (Snecify)	
5	ding Phy th. After thi funeral		27. Manner of Death 28a. Da		o. Time of Injury	28c. Injur Wor		8d. Describe ho			
	I or Atten after dea Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Pla	ce of Injury - At home, ding, etc. (Specify)	farm, street			8f. Location (Str City or Town,		er or Rurel I	Route Number,
	Hospita 24 hours Funerel stely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the Check only one) 2 Medical Examiner: Oythe and medical Examiner.	ne best of my knowled basis of examination a	lge, death or and/or inves	ccurred et the tin tigation, in my o	ne, date and place, e pinion, death occurre	nd due to the ca d at the time, da	use(s) end ma te and place, a	nner as stat and due to th	ted. he cause(s)
	To the within To the comple		29b. Signature and title of certifier	annor stated.		29c. Licens	e number		d. Date signed	l (Month, Da	ay, Yeer)
0		-	30. Name end address of person who combleted ca	use of death (Itam 33)	a) (Type Pri	D3.	3426		7-18	-02	5
1	88		Larry Jenkins, M.D.	111 LaGr	ange	Ave.	La Plata	,MD 2	0646		
I	Stat Registra	.5	31. Date filed (Month, Day, Year) JUL 2 0 2005 32.	Resistrar's Signature	do	who !					

DHMH 16 Rev 6/95

		partment of Health and Mental Hygertificate of Death	piene 005 25253
Physiciar	1. Decedent's Name (First, Middle, Last)	2. Date of Deal Month	th 3. Time of Death
/Medica Examine	As Estilla Alexander of the state of the sta	4b. City, Town, or Location of Death	Day Year 9 42 PM 4c. County of Death
	DOCTOR'S COMMUNITY HOSPITAL	LANHAM	PRINCE GEORGE'S
Funeral Director	5. Social Security Number 6. Sex 1 M 2 T F 7. Age (In yrs. last birthda) 7. Age (In yrs. last birthda) 7. Age (In yrs. last birthda)	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, APRIL 2	9. Birthplace (State or Foreign Country) Vear) VIRGINIA
9	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or 1		10d. Inside City Limits
Mary e-f she			1 X Yes 2 □ No
death with the Maryland ms 23a or 28e-f show triviate notified at	10e. Street and Number 5903 OSAGE STREET		0g. Citizen of What Country?
6 Sitter death vor items 23s	11. Marital Status	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	UNITED STATES 14. Race - American Indian,
36 Satter is atter		1 ☐ Yes 2 No Specify:	Black, White, etc. Specify: BLACK
21215-003 21215-003 9giene. "natural", c. 1, the Medical Exp.	15. Decedent's Education (Specify only highest grade completed) (Giv	edent's Usual Occupation	16b. Kind of Business/Industry
within see.	Elementary/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of working DO NOT use retired) MAKER	DDTWAME
Ind 2 Be filed tal Hygid do ther event, III		18. Mother's Name (First, Middle, M	PRIVATE Maiden Sumame)
Maryland 21215-003 Maryland 21215-003 d 2 should be filed within 72 hours; th and Mental Hygiene, and Mental Hygiene, traumatic event, the Medical Exp. To Re Commissed by	WILLIAM GASKINS	ROSA GASKINS	
_ 2 # N r		ling Address (Street and Number or Rural Route Number, ROOSEVELT BLVD, #A-724, FALLS Q	
Baltimore, semil. Pages 1 a Department of Hee mportant: If item my injury or othe bice.		51 At 1	20c. Location - City or Town, State
altim nit. Pa antmen ortant: injury	' 4 □ Donation 5 □ Other (Specify) 21. Singler of Fence is Servery 22. Singler of Fence is Servery 23. Singler of Fence is Servery 24. Singler of Fence is Servery 25. Singler of Fence is Servery 26. Singler of Fence is Servery 27. Singler of Fence is Servery 28. Singler of Fence is Servery 29. Singler of Fence is Servery 21. Singler of Fence is Servery 22. Singler of Fence is Servery 23. Singler of Fence is Servery 24. Singler of Fence is Servery 25. Singler of Fence is Servery 26. Singler of Fence is Servery 27. Singler of Fence is Servery 28. Singler of Fence is Servery 29. Singler of Fence is Servery 29. Singler of Fence is Servery 20. Singler of Fence is Serve	22 Name and Address of Eacility	HELITHAM, MARYLAND
Bal permi Depa Impo eny ii	DENTAL TURNING PRATOR MANAGEZ	22. Name and Address of Facility ORNTON FUNERAL HOME, P.A. 439 LIVINGSTON ROAD, INDIA	N HEAD, MD 20640
	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final	nter the mode of dying, such as cardiac or respiratory arre	Approximate Interval Between
/Medical	disease or condition resulting in death) a. Due to (or as a consequence of):	SIVE CARDIOVASCU	LAR DUSERSE
Examiner	Sequentially list conditions, b.		
D, executed in and ial-transit Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		
ate the the	d		
Box 68 leath certificate attending pt attending pt affor use as tt	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1□Live birth 2 □ Fetal death 3	□Ectopic pregnancy	23d. Date of delivery
P.O. I hat the ded by the a detached f	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)	Month Day Year
IS, P.O. I res that the de signed by the a be detached the by Physic	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did tob	acco use contribute to the cause of death?
al Record: The law require cate has been sir page 2 should be completed.	GORDIAN HAVEN DIZECTE	N 0 +	s 2 No 3 Probably 4 Unknown
Rec The lav te has age 2	Anemia Chinal Steuss	Demenia 24a. Was an autopsy perform	prior to completion of cause of death?
f Vital Reysidan: The last certificate he director, page	25. Was case referred to medical examiner?	26. Place of Death (Check only one	2 No 1 □ Yes 2 □ No
Of \Officerror			
rision of Attending Ph death. ctor: After thi y the funeral	1	of 28c. Injury at Work? M 1 Yes 2 No	in injury occurred
Division of Vital Records, ital or attending Physician: The law requires the staffer death. al Director: After this certificate has been signed in by the funeral director, page 2 should be a Certification: To Be Completed by	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28e. Place of Injury · At home, farm, st building, etc. (Specify)	reet, factory, office 28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician/Mer		h occurred at the time, date and place, and due to the car ivestigation, in my opinion, death occurred at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)
To the within To the comple	29b. Signature and title of certifier		d. Date signed (Month, Day, Year)
	1 Wahan Miss		7-18-2005
131	30. Name and address of person who completed cause of death (Item 23a) (Type, Nee Cam Ashou 4410 7415	Ave landoverfills	MD 20784.
State Registrar	31. Date filed (Month, Day, Year) JUL 2 0 2005 32. Reflistrar's Signature	porte	· ·

			For State	State of Marylan		ment of Healt		/	2000	25255
	Physici	an	Registrar Decedent's Name (First, Middle, Last)	(1)		i	2.	Reg. No Date of Death Month Da		3. Time of Death
	/Media	al	4a Fecility Name (If not institution, give	street and number)	BROC	b. City, Town, or Locati		uly 16	2005 County of Death	10:35 p M
	Examir	er	Clinton Nursing	Rehab. Cen	Her	Clinton		P		eorges
	Funeral Director		5. Social Security Number 6. St	9X 7. Age (In yrs. I	ast birthday) N	f Under 1 Year If Un Ionths Days Hou	nder 24 Hrs. 8.	Date of Birth Month, Day, Year, ptember 2	1913 9. Birth	hplace (State or Foreign untry) 184 IANO
	pu *		Usual Residence of Decedent 10a. State 10b. County	10c. Cib	/. Town or Locat	ion		pidiween		10d. Inside City Limits
	a-f eho	ctor	MARULAND PRINCE G	EDRGES BE	ANdyw	ine				1X Yes 2 □ No
	with the	Funeral Director	10e. Street and Number	D 1		10f. Zip Code	2	10g. Ci	itizen of What Cou	untry?
	ms 23	nerai	1311 Moores	12. Was Decedent Ever in U. Amged Forces?	S. 13. Wa	s Decedent of Hispanic es, specify Cuban, Mex	Origin? (Specify	Yes or No-	14. Race - Amer	
36	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-1 ehow adical Externier must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 XYes 2 □ No If Yes, Give Year or Dates: ↓ / 1 →		Yes 2 No Spec		(11, 610.)	Specify:	, oic.
21215-0036	72 hou natura	eted I	15. Decedent's Ed (Specify only highest gra	lucation	(Give kin	t's Usual Occupation d of work done during n	most of working		(ind of Business/	*
121	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Bus	NOT use retired) DRIYER		BAR	nce Ge	ducations
		Be	17. Father's Name (First, Middle, Last)	77		18. M	_	rst, Middle, Maider	,	
Maryland	2 should be and Mental is marked of aumatic ev	은	19a. Informant's Name/Relationship	Brooks Type, Print)	19b. Mailing /	Address (Street and Nu	MANNIE			
	1 and 2 s Health ar tem 27 is		Edward Brooks /	SON	75101	Moores Bd	Brandy	WINE M	aruland	20613
altimore,	0 0		20a. Method of Disposition 1 Burial 2 Cremation 3 1 Description 5 College (Secret	Removal from State	1/1	ory or other place)	Date	105 AL	ocation - City or I	Town, State
altin	permit. Pag Department Important: I any Injury o		*4 □ Donation 5 □ Other (Specify 21. Signature of Fluneral Service Licen	11.11		ANS Cem ame and Address of Fa	acility	703 Ch	ELTENTIA	MI PID
B B	99 2 2 9		23a Part 1 Enter the disease or comp	plications that caused the death	Po not enter t	AMS FUNCE	Al Homo	P.A.A.	quasco	MD 20608 Approximate
	Physician		23a. Part1. Enter the disease, or comp shock, or hear failure. List only Immediate Cause (Final disease or condition	one cause on each line.	1. 16.	HERT ?				Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ		141/4	3 4 4 4			
Ы		ner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequ	terico di).					
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequ	sence of):					
8760,	ate be e hysician the buriz	dicai E		d						
9	eath certifica attending ph for use as tl	ě.	IF FEMALE:	23c. If yes, outcome of pregnal	ncy				23d. Date of deliv	verv
). Box	The law requires that the death certificate be executed tte has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		topic pregnancy ther (specify)			Month	Day Year
P.0	that the de red by the detached		9 ☐ Unknown Part II. Other significant conditions or		ulting in the unde	rlying cause given in Pa	art I.	23e. Did tobacco	use contribute to	the cause of death?
ords	w requires been sign should be	ted by						1 ☐ Yes 2	No 3□ Pro	bbably 4 Unknown
Records,	e law re has be ge 2 sh	Completed						24a. Was an autopsy performed?	24b. Were aut prior to co death?	topsy findings available completion of cause of
Vital B	(0)	a	25. Was case referred to medical			26. P	lace of Death (C)	1 ☐ Yes 2 No		2 No
of Vi	Phyelcian: this certific ral director,	To B	1 Yes 2 No			3□ DOA Other: 41	Nursing Home	5 Residence		ify)
	Ing Affer une	tion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2		Describe how inju	ry occurred	
Division	I or Attendil after death. Director: A I in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street	factory, office		Location (Street ar City or Town, State		ral Route Number,
	Hospital or 14 hours afte Funeral Dire tely filled in 8			ysician: To the best of my know						
	To the Hospitel within 24 hours of To the Funeral completely filled	Medical	one)	iner: On the basis of examinat and manner stated.	ion and/or invest	29c. License numb				
	T with	~	29b. Signature and title of certifier	1114		D3 (2		290. Da	ate signed (Month	Day, real)
	4		30. Name and address of person who	completed cause of death (Item	23a) (Type, Pri			79	18.	<u>6003</u>
35	Sta	te	31. Date filed (Month, Day, Year)	completed cause of death (Item 100 1 32. Registrar's Signat	Living	itm icac.	for was	Hingt wy	mayon	·0 20744
	Regist		JUL 2 0	2005 Henre	1. Ap	ere				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. U Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 11:45 A N **Physician** July 25, 2005 Catherine Inez Boswell /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner 24710 Budds Creek Road St. Mary's Clements If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 X F Director 78 Oct 31, Maryland 218-30-3409 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits show 10a State 10b County Examiner rount be notified at 1 ☐ Yes 2 No Director 28e-f Maryland St. Mary's Clements 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ō Items 23a 24710 Budds Creek Road death v 20624 USA Funera 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ont: If item 27 le marked other than "natural", or Iter 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White Specify: If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Credit Bureau 12 Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nicholas Langley 0 Jane S. Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 le any injury or other trace once. 24710 Budds Creek Road, Clements, MD Martin A. Boswell/Husband 20624 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a, Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery July 28,2005 Brentwood, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 21. Signature of Funeral Service P. O. Box 270, Leonardtown, Maryland 20650 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** aros /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed ig physician and as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical attending IF FEMALE esn If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year ō Month Day 4□Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 No 9 ☐ Unknown the à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy 1□ Yes 2 No certificate Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director Be examiner' Other: 4 Nursing Home X Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 2 ihis 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 2 Accident 5 Pending death. investigation hours after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 74 ☐ Homicide 124 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature a title of certifie 14285 d cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete Dr. William D. Boyd II, 25365 Pt. Lookout Road, Leonardtown, Maryland 20650 31. Date filed (Month) ULY2'6 State 2005 Registrar

			1- State of Maryland / Department of Health and Certificate of Death		211115	25257
			Decedent's Name (First, Middle, Last)	2. Date of Dea	Reg. Ner UUU	3. Time of Death
п	Physic		Charles Henry Bennett, Sr.	Month	Day Year 2005	
	/Medi Exami		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of De	7 7 2 3 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
		ici	St. Mary's Nursing Center Leonardtown	.,	St. Ma	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.			
	Director		216-12-4587 10XM 2 F 84 Yrs. Months Days Hours Min.	(Month, Day Aug. 1		irthplace (State or Foreign Country) Iaryland
	TO TO		Usual Residence of Decedent	1106 - 1	, 1720 1	aryrand
	rylar how	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	te-f	cto	Maryland St. Mary's Lexington Park	> ,		1 ☐ Yes 2 No
	or 26	- Le	10e. Street and Number 10f. Zip Code		10g. Citizen of What 0	Country?
	23e	a	22007 Valley Drive Estate, Apt. #229 20653		United S	tates
	ler death w Items 23e	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puen	Specify Yes or No-	14. Race - Am Black, Wh	
36	or In	by Fu	1 Never Married 2 Married 1 Yes 2 No 1942-	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	Specify:	1110, 010.
00	hour	g p	3 ■ Widowed 4 □ Divorced Year or Dates: 1945		B	lack
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or items 23e or 28e-f ahow he Medical Exantine must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of work life. DO NOT use retired.]	rking	16b. Kind of Busines	s/Industry
12	withi ene.	m C	Elementary/Secondary (0-12) College (1-4or 5+)		D C1	- C T 1
	filed withii Hygiene. other than		7 Cleaner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	me (First, Middle,		r & Laundry
Maryland	2 should be filed withir and Mental Hygiene. is marked other than sumatic event, it. M.	To Be			,	
7	should ind Men s marke umatic	F	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru	Victoria		Zia Codo)
N	and 2 sealth ar n 27 is		Peggy Wade / Daughter P.O. Box 302, Califo			
ā,	- 7 S S		20a. Method of Disposition 20b. Place of Disposition (Name of	Date Ma	20c. Location - City o	
Baltimore,	pernit. Pages Department of H Important: If its any injury or of		1 Burial 2 □ Cremation 3 □ Removal from State *4 □ Donation 5 □ Other (Specify). The second of the place	2005		
豈	it. P		Inmaculate neart of	-2005	Lexington	Park, MD
Ba	Dep Important any r		Cilially Qu	rinsfield	d Funeral	Home, P.A.
			Edward N. Brinsfield, Jr. M00052 P.O. Box 279 Leons 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each limb			Approximate
			shock, or heart failure. List only one cause on each line. Immediate Cause (Final		000,	Interval Between Onset and Death
	Priysician /Medical		disease or condition resulting in death)		_	145
	Examiner		Due to (or as ponse proce of			A.
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			590
	uted d ansit	E I	cause. Enter Underlying Cause (Disease or injury I that initiated events			U
Ć,	exec n an	Examiner	resulting in death) Last Due to (or as a consequence of):			
8760,	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dical	C _d			
68	tificat ig phy as th	l w				
Вох	death certifica attending ph if for use as t	N/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of de	livery
B	deatl e atte	Physiclan/M	in the past 12 months? 1		Month	Day Year
P.0	at the de by the tached	hys	9 ☐ Unknown			
6	igned be de	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	bacco use contribute t	o the cause of death?
ğ	w require been sig should b			1 □ Ye	as 2.∰ No 3 □ P	robably 4 DUnknown
Records,	aw re	Completed		24a. Was a		utopsy findings available
Ä	: The lav cate has	E O		autops perform	ned? death?	completion of cause of
Vital	certifica rector, p	a	25. Was case referred to medical 26. Place of Dea	ath (Check only on		s 2 X No
V	S D	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 X Nursing Hospital:			ecify)
	ding Ph h. After th funeral		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		ow injury occurred	,,
Ö	uttendir death. ctor: Af y the ful	atlo	2 Accident investigation M 1 Yes 2 No			
Division	I or Attending after death. Director: After i in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St. City or Town	reet and Number or R	ural Route Number,
	Italor A rsafter ral Directed in by	Cer	g:(-r//	0.0, 0.70.	, Glalo)	
	e Hospital of 24 hours at Euneral Detely filled i	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, (Check only one) 2 Medical Examiner: On the place of examination and/or investigation, in my opinion, death occur	, and due to the ca	ause(s) and manner a	s stated.
	To the Hospital within 24 hours a To the Funeral (completely filled	Medi	ana manner stated.			
	To With	2	29b. Signature and title if certifier 29c. License number	10	9d. Date signed (Moni	th, Day, Year)
,	201		I Jamest No Wast 1 06 71	17	1-26-	-05
-	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
	-		J. Patrick Jarboe, M.D., 24035 Three Notch Road, Holl	Lywood, M	Maryland 20	0636
	Sta Registr		31. Date filed (Mohitf, Day, Year) 32. Registar's Signature			

			For			nd / Depa	artment	t of Health an	•		-	
				-4)		Ce	rtificate	e of Death		Reg. N	-2005	25250
	Physic	an	1. Decedent's Name (First, Middle, La. Thelma Jean Bitt	•					2. Date of Month	D	ay Year	O. Timo OPDORGIGE
	/Medi Examir		4a. Facility Name (If not institution, give				4h City	Town, or Location of D	JULY		2005	10:10A M
	Examir	ier						berland	eam		c. County of Dea	
	Funeral		Memorial Hospital 5. Social Security Number 6. S	L & Medica ex 7.Ag	e (In yrs	nter . last birthday)	If Under	1 Year If Under 24	Hrs. 8. Date of	Birth	Allegany 9. Bi	rthplace (State or Foreign
	Director		220–26–9780	□ M 2 X F	77	7 Yrs.	Months	Days Hours A	March	Day Year	1.928 Mar	yland
	pur *		Usual Residence of Decedent 10a. State 10b. County		100 C	ity, Town or La						
	/anyla	ō	MD Garrett									10d. Inside City Limits 1 ☐ Yes 2 1 No
	the 288-	Director	10e. Street and Number		LOI	naconin	10f. Zip	Code		10- 0	itizen of What C	
	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ehow he Medical Examinar must be notified at	D	3580 Avilton-Lona	coning Ros	nd.			539		US		ountry?
	death	Completed by Funeral	11. Marital Status	12. Was Decedent Armed Forces?		J.S. 13. \		ent of Hispanic Origin? ify Cuban, Mexican, Pi	(Specify Yes or		14. Race - Am	erican Indian,
9	or its	/Fu	1 ☐ Never Married 2 Married	1 Yes 2	No		rγes, speci 1 ∐ Yes 2		Jerto Hican, etc.)		Black, Whi	ite, etc.
ğ	ural',	q p	3 Widowed 4 Divorced	Year or Dates:							Specify: Wh	ite
7	n 72 "nat	lete	15. Decedent's Ed (Specify only highest gra	ucation de completed)		(Give	dent's Usual kind of worl DO NOT use	l Occupation k done during most of	working	16b. F	Kind of Business	s/Industry
12	withi iene. then	dmo	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Seams		e retired)		Тез	ktile	
Maryland 21215-0036	illed Hyg other	Be C	17. Father's Name (First, Middle, Last)					18. Mother's I	Name (First, Midd			
<u>a</u>	Juid be Jenta rked tic ev	To B	Earl Resh					Oma P	latter			
<u>a</u>	2 sho and h is ma		19a. Informant's Name/Relationship (7					(Street and Number or				
	and sealth m 27		Orval Bittinger/Hu	usband				on—Lonacon:	ing Rd.,	Lona	aconing,	MD 21539
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Examinat must be notified at ances.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	20b. I	Place of Disportance	sition (Name natory or oth	e of her place)	Date	20c. L	ocation - City or	Town, State
Baltimore,	t. Pa rtmen rtent:		* 4 □ Donation 5 □ Other (Specify)	Gra			metery Jul				
e n	Depon Impo any any		21. Signature of Funeral Service Ucen:	see Umalu)			Address of Facility				
		Н	23a. Part1. Enter the disease, or comp		the deal			ox 275, Gra			21536	
	Dhusisian		shock, or lear failure. List only o		10.	00 1101 01111	31 1110 111000	ror dying, such as care	nac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Sepsis Due to (or as	2 000000	ruence of\-						
	Examiner			Perfora								1 week
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	tuence of):						
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
Ď,	ate be executed hysician and the burial-transit	cai E	and a sain, sain	Due to (or as	a conseq	ruence of):						
09/90	death certificate e attending physicifor use as the		•	d								
XOO	Jeath certifical attending phy I for use as th	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregna	ancy					22d Date of de	li can
Ď	death e atte d for	Iclai	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pred				23d. Date of del Month	Day Year
		Physician/Med	9 ☐ Unknown	9□ Unknown								
ń	Physician: The law requires that the de trinis certificate has been signed by the r ral director, page 2 should be detached	by F	Part II. Other significant conditions co	ntributing to death bu	ut not res	ulting in the un	derlying cau	use given in Part I.	23e. Dio	tobacco i	use contribute to	the cause of death?
	een s sould	ted							_ 1	Yes 2	XINo 3□Pr	obably 4 Unknown
ב	a faw has b e 2 st	Completed							24a. Wa	is an	prior to	stopsy findings available completion of cause of
	r. The	S							per 1 ☐ Yes	formed2	death?	2□ No
V [siciar certif rector	o Be	25. Was case referred to medical examiner?	Hospital:				Other	eath (Check only			
5	Phys r this aral di	H .	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injur	-	ER/Outpatient 28b. Time of		c. Injury at	Home 5 Res			cify)
5	nding tth: :: Alte e fune	tio	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year)	Injury	м	Work? 1 ☐ Yes 2 ☐ No	200. Describe	o now injui	у оссилеа	
2	Atter	Hice	3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At ho	ome, farm, stre	et, factory,		28f. Location	(Street an	d Number or Ru	ıral Route Number,
5	s afte	Certification:	4 Homicide	building, etc	. (Specify	y)			City or To	own, State)	
	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director: Alter this certificate has completely filled in by the funeral director, page 2.		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best o	f my kno	wledge, death	occurred at	the time, date and pla n my opinion, death oc	ce, and due to the	e cause(s)	and manner as	stated.
	the the the the the the the the the the	Medical		and manner star	ted.	and and of mive			Curred at the time			
	S with S		29b. Signature and title of certifier	-UN			29c. 1	License number			te signed (Monti	
		-	20 None and			a . =		D23371		July	24, 20	105
	9		30. Name and address of person who con Dr. Q. Zaman, John					. Cumberl	and. MD	2150)2	
	Stat	е	31. Date filed (Month, Day, Year)	32. Registra		ture	1		,			
	Registra	ır	JUL 2 6 2	.005	ASS.	Dr. A	and the	?				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** July 2005 Violet Maye BACHTELL /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington 1417 Kensington Drive Hagerstown If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 27 ☐ F 1904 101 Maryland Director 820-04-4252 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Itama 23a or 28a-f show the Mudical Examinar must be notified at 1 ☐ Yes 2 ☐ No Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 1417 Kensington Drive 21742 Completed by Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 0-11 College (1-4or 5+) Homemaker Her own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary M. Hause Edward S. Foltz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) itam 27 1417 Kensington Dr. Apt. 102 Hagerstown, Md. Joseph S. Bachtell -Son other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition permit. Pages 1 Department of H Important: If its any injury or of once. 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 7/22/05 Hagerstown, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Minnich Funeral Home Usal 415 E. Wilson Blvd. Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ASCULAR Immediate Cause (Final disease or condition resulting in death) merch one **Physician** /Medical Examiner 10SCLIZRO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months 5 Other (specify) 4 Pregnant at time of death signed by the a ☐Yes 2 CN Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s 2 No certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 1 Yes 2 -11 this 28d. Describe how injury occurred 27. Manty 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? of Death Certification: After 1 Natural 5 Pending investigation 1 □ Yes 2 □ No death. 2 Accident Director: Vithin 24 hours are. .

To the Funerel Director 6 ☐ Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title 28 Logerston

State Registrar

2005

			1 - State of Maryland / D	epartment of Certificate of		, ,	iene	
	Physic /Medi		Decedent's Name (First, Middle, Last) ADAM TIMOTHY BROWN			2. Date of Death Month JULY 20	h Day Year	3. Time of Deam 11:25 A ^M
	Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town	n, or Location of Deatl		4c. County of Dea	
1	2	P	1915 ROHRERSVILLE RD 5. Social Security Number 6. Sex 7. Age (In yrs. last birth		NSVILLE par If Under 24 Hrs.	T 0 B 1 1 (B) 1	WASHING	
	, Funeral Director		130 (F 1110	rs. Months Da		8. Date of Birth (Month, Day, DEC. 8,	1986 TEI	rthplace (State or Foreign Jountry) NNESSEE
	yland		10a. State 10b. County 10c. City, Town	or Location				10d. Inside City Limits
	8a-f si	Director	MARYLAND WASHINGTON	BROV	NSVILLE			1 □Yes 2X No
	with the	Dire	10e. Street and Number 1915 ROHRERSVILLE ROAD	10f. Zip Cod		10	g. Citizen of What C	•
	death	Funerai	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent	21715 of Hispanic Origin? (Sluban, Mexican, Puert	pecify Yes or No-	U.S.	
036	be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or trams 23a or 28a-f show event, the Medical Exertinar meat to notified at	by	1 ⚠ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	If Yes, specify C 1 □ Yes 21/27 N		o Rican, etc.)	Black, Whi	te, etc.
1215-0036	n 72 ho natur	Completed	(Specify only highest grade completed) (Decedent's Usual Occ Give kind of work do	ne during most of wor	kina 1	6b. Kind of Business	VHITE VIndustry
	l within lene. r than	omp	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use ret CREW TF	rired)		ACT FOOD	
nd	al Hygier s other th	BeC	17. Father's Name (First, Middle, Last)	CKEW IF		ne (First, Middle, M		RESTAURANT
Maryland 2		2	CHARLES T. BROWN		KATHY F			
	32 s h ar 7 is trau				et and Number or Ru.			
saltimore,	of H		20a. Method of Disposition 20b. Place of D	Disposition (Name of crematory or other p	SVILLE ROAI		VILLE MAI 0c. Location - City or	
Ĕ	permit. Pages Department of Important: if it any injury or o		4 Donation 5 Other (Specify) BROWNSV	ILLE HGTS.	CEM. 7/2	5/2005 B	ROWNSVILL	E, MARYLAND
g	Departiment of the particular		21. Sign fure of Fureral September 19 Paul M. Dean	22. Name and Add BAST FUNE	dress of Facility ERAL HOME	7606 01d	National o,Marylan	Pike
	- 1 d		23a. Part I. Enter the disease or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of d	lying, such as cardiac	or respiratory arres	st,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of	Lotqu	w Warn	dot the	od	Onset and Death
	Examiner		es were - be					
	nsit	nine	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)					
'n	execut an and rial-tran	Examin	that initiated events c c Due to (or as a consequence of)					
00/00	ficate be executed physicien and is the burial-transit	edicai	d					
o X	ding		IF FEMALE: 23c. If yes, outcome of pregnancy					
0	0 00	Physician/M	in the past 12 months? 1 Yes 2 No 1 Live birth 2 Fetal death 4 Pregnant at time of death	3 □Ectopic pregnant 5 □ Other (specify)	ncy		23d. Date of del Month	Day Year
	hat the od by th Jetach		9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the					
, Z	The law requires that the diate has been signed by the page 2 should be detached	_	the state of the s	ie underlying cause g	given in Part I.	1 Tes	cco use contribute to	the cause of death? obably 4 Unknown
ב ב	e law r has be	Completed				24a. Was an autopsy	prior to d	topsy findings available completion of cause of
	ician: Th certificate rector, pag	CO	25. Was case referred to medical			1/	d? death?	
>	trending Physician: The la Jeath. tor: After this certificate has the funeral director, page 2	ToB	examiner? 1 M Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	atient 3 DOA	ther	n <i>CHock</i> ont one me 5□ Residend	ce 6 XOther (Spec	SCHNE
2	ing Pr		27. Manner of Death 1 □ Natural 5 □ Pending 28a. Date of Injury 28b. Tim (Month. Pay Year) Injury Injury 1 (Month. Pay Year)	ne of 28c. Inj		28d. Describe how		LO
2	Attend death ctor: / y the f	ficat	2 Accident investigation // 2005	_ M 1[☐Yes 207No	Subjec	18 Lest s-	eft
5	s after s Dire	Certification:	4 Homicide determined 256. Place of Injury - At nome, farm building, etc. (Specify)	Street, factory, office	-	City or Jown, S	et and Number or Ru State)	PA Houte Number,
		Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, d (Checomology) Medical Examiner: On the basis of examination and/o	eath occurred at the	time, date and place,	and due to the caus	se(s) and manner as	stated.
	within 2	Med	and manner stated. 29b. Signature and tyle of certifier		nse number		. Date signed (Month	
'			(Cohem)		СМ Е		ULY 21, 20	
<i>i.</i> 1	-3		30. Name and address of person who completed cause of death (Item 23a) (Ty		INI CIPILITIES			
	Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature		N STREET,	BALTIMOR	E, MARYLAN	ND, 21201
	Registra	r	JUL 2 2 2005	Snarles				

			1 - For State of Maryland / Dep	eartment of Health and Mertificate of Death		ene	00001
			Decedent's Name (First, Middle, Last)		2. Date of Death	- C U U	3. Time of Death
	Physici /Medi		Michael P. Bauer		Month July	Day Year 16 2005	7:00 P M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	,	4c. County of Dea	
		*	Casey House	Rockville		Montgome	ry
L	Funeral Director		5. Social Security Number 211-60-8186 6. Sex 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y March 5,	9. Bir 1966 PA	thplace (State or Foreign ountry)
	and w		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Mary f sho	ō					1 ☐ Yes 2X No
	the 28e	Director	MD Montgomery Montgo	mery Village 10f. Zip Code	100	J. Citizen of What C	
	3a o	Ö	9735 Lakeshore Drive	20886			
	death	Funerai		Was Decedent of Hispanic Origin? (Spi If Yes, specify Cuban, Mexican, Puerto		United St	
21215-0036	d within 72 hours after death with the Maryland jiene. r then "naturel", or Items 23a or 28e-f show the Medical Examinar must be notified at	by	1	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	Rican, etc.)	Black, Whi	te, etc. White
Ö	72 ho	Completed	15. Decedent's Education 16a. Dece	edent's Usual Occupation	16	b. Kind of Business	Andustry
21	within 7 ene. then "r	ple	(Specify only highest grade completed) (Give life.	e kind of work done during most of worki DO NOT use retired)	ng		•
7	filed with Hygiene. other ther	Con	4 Gen	eral Manager		Food Ser	vice
nd	be filed tal Hygid d other	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Ma	iden Sumame)	
yla	2 should be a and Mental is marked o	ို	Clement Bauer	Regina			
			19a. Informant's Name/Relationship (Type, Print) Carol Bauer/ Wife 9735	ng Address (Street and Number or Rura Lakeshore Drive,	<i>Montgome:</i> Montgome:	City or Town, State, . ry Villag	^{Zip Code)} 20886 e, MD
altimore,	of He			matory or other place)	ate 20	c. Location - City or	Town, State
Ĕ	mit. Pages partment of sortent: If in injury or		4 □ Donation 5 □ Other (Specify) Queen of	: 22	23 ₅ Pe	eters Tow	
Ball	permit. Pages 1 and Department of Healt Importent: If item 2 eny injury or other once.		21. Signature of Funeral Service Licensee D	2. Name and Address of Facility De eer Park Drive, Ga	Vol Funer ithersbu	ral Home, rg, MD 20	10 East 877
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac o	r respiratory arrest		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Abdominal C	arcinomatosis			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
	Lamine	<u>.</u>	Sequentially list conditions, b. Advanced, r	efractory small bo	wel cance	er	
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	icate be executed physician and s the burial-transit	хап	that initiated events resulting in death) Last Due to (or as a consequence of):				
8760,	be e sician buria	aiE	355 15 (2. 25 2 55),52425,155 51).				
687	ficate phy: s the	edicai	d.				
Вох	The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of del	wen/
m.	death e atte	icia	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		Month	Day Year
О	that the de led by the a detached f	hys	9 ☐ Unknown 9 ☐ Unknown				
S,	res tha igned be det	ру Р	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
<u>S</u>	w requir been si should l				1 ☐ Yes	2 X No 3 □ Pr	obably 4 Unknown
Record	law r as be 2 sh	Completed			24a. Was an autopsy	24b. Were au	topsy findings available
<u>~</u>		NO.			performed	death?	completion of cause of 2 No
Viital	cien: ertific ector,	Be (25. Was case referred to medical examiner?	26. Place of Death			
=	ling Physicien: After this certifications of the control of the c	P	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	nt 3 DOA Other: 4 Nursing Hom	ne 5 🗆 Residence	e 6X1Other (Spec	(ify) Hospice
		Certification;	27. Manner of Death 1 X Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) Injury	f 28c. Injury at 2 Work?	8d. Describe how i	njury occurred	•
S	Attending ar death. ector: After by the fune	cat	2 Accident investigation	M 1 Yes 2 No			
\leq	or Attency after death Director: I in by the	ertif	4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office 2	8f. Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
_	spitel ours (lerel)	2	29a. Certifier 12T Certifying Physician: To the best of my knowledge death				
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Aedicai	(Check only one) 4 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurre	nd due to the caused at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	z w c o	Σ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	, Day, Year)
	12	-	Maller	1 1191218		+/1+/c	5
			30. Name and address of person who completed cause of death (Item 23a) (Type,			/ - /	
			Charles Harrison, M.D., 6001 Muncaste 31. Date filed (Month, Day, Year) 32. Registrar's Signature	er Mill Road, Rocky	ville, MD	20855	
	Sta Registra		31. Date filed (Month, Day, Year) JUL 2 0 2005 37 Registrar's Signature	ule)			

Registrar DHMH 17 Rev 1/2001

State

Division of Vital Records, P.O. Box 68760

State of Maryland / Department of Health and Mental Hygiene Certificate of Death S. Thele of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Bake ヒロノナト JIII.Y 2005 12:00 PM 15 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner ASSISTED LIVING OF ANNAPOLIS ANNAPOLIS ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1 M 2 X F Yrs. Director 410-22-2333 82 SEPT. 27, 1922 TN Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f ehow other treumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No QUEEN ANNE'S CHESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 2 C QUEEN VICTORIA COURT 21619 Completed by Funeral USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. illed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: WHITE 3 Widowed 4 □ Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME other 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be file treent of Health and Mental Hy tant: If item 27 is marked oth 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN NEWTON FRYER RUBY LOU (UNKNOWN) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) REBECCA PANEX/DAUGHTER 2 C QUEEN VICTORIA COURT, CHESTER, MD 21619 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Important: If it MARYLAND VETERANS CEMETERY Burial 2 □ Cremation 3 □ Removal from State • 4 ☐ Donation 5 ☐ Other (Specify) 07/20/2005 HURLOCK, MD 21. Signature of Funeral Se 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
106 SHAMROCK ROAD, CHESTER, MD 21619 DUCE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner 2/5 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-trar and Due to (or as a consequence of) Box 68760. Completed by Physician/Medical the attending IF FEMALE: use 23c. If yes, nutcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy ŏ Month Year 4□Pregnant at time of death 5 Other (specify) detached P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, pe 1 ☐ Yes 2 ☐ No. 3 Probably 4 Minknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 6 24a. Was an has autopsy certificate 1 ☐ Yes 2 E No Hospitel or Attending Physician: 25. Was case referred to medical examiner? director. Be 192516 Je 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No しょびい Medical Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA this the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of After 5 Pending investigation 1 Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funerel C 1 Sentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 170 32. Registra's Signature 31. Date filed (Month, Day State 0

Registrar

		4	epartment of Health and M	lental Hygie	ene	25061
		Registrar	Sertificate of Death		CUU SAN	79797
Physi	cian			2. Date of Death Month	Day Year	3. Time of Death
-E-1	Decodors Steiner (Prof. Models, Last) NORMA JEAN BELL SCHINGTON NORMA JEAN BELL SCHINGTON As Facility Name (Prof. Models, Last) NORMA JEAN BELL SCHINGTON As Facility Name (Prof. Models, Last) NORMA JEAN BELL SCHINGTON As Facility Name (Prof. Models, Last) NORMA JEAN BELL SCHINGTON As Facility Name (Prof. Models, Last) NORMA JEAN BELL SCHINGTON As Facility Name (Prof. Models, Last) NORMA JEAN BELL SCHINGTON As Facility Name (Prof. Models, Last) NORMA JEAN BELL SCHINGTON As Facility Name (Prof. Models, Last) NORMA JEAN BELL SCHINGTON As Facility Name (Prof. Models, Last) NORMA JEAN BELL SCHINGTON As Facility Name (Prof. Models, Last) NORMA JEAN BELL SCHINGTON As Facility Name (Prof. Models, Last) NORMA JEAN BELL SCHINGTON As Facility Name (Prof. Models, Last) NORMA JEAN BELL SCHINGTON As Facility Name (Prof. Models, Last) NORMA JEAN BELL SCHINGTON As Facility Name (Prof. Models, Last) NORMA JEAN BELL SCHINGTON As Facility Name (Prof. Models, Last) NORMA JEAN BELL SCHINGTON As Facility Name (Prof. Models, Last) NORMA JEAN BELL SCHINGTON As Facility Name (Prof. Models, Last) NORMA JEAN BELL SCHINGTON As Facility Name (Prof. Models, Models) As Facility Name (Prof. Models, Models) As Facility Name (Prof. Models, Models) As Facility Name (Prof. Models, Models) As Facility Name (Prof. Models, Models) As Facility Name (Prof. Models, Models) As Facility Name (Prof. Models, Models) As Facility Name (Prof. Models, Models) As Facility Name (Prof. Models, Models) As Committed Tools of the Supersory (Prof. Models, Models) As Committed Tools of the Supersory (Prof. Models, Models) As Committed Tools of the Supersory (Prof. Models) As Committed Tools of the Supersory (Prof. Models) As Committed Tools of the Supersory (Prof. Models) As Committed Tools of the Supersory (Prof. Models) As Committed Tools of the Supersory (Prof. Models) As Committed Tools of the Supersory (Prof. Models) As Committed Tools of the Supersory (Prof. Models) As Committed Tools of the		3:50A ^M			
Exan	niner					l a
D.	y.					
		219-22-3715 1□M 2\ F 76	Months Days Hours Min	NOV.4, 1	(ear) 9. Birthp Coun 928 MAR	
land ow			or Location		11	Od. Inside City Limits
Many 9-f ah	tor	MD QUEEN ANNE'S STEV	/ENSVILLE			1 ☐ Yes 2 🕱 No
th the	lrec	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Coun	try?
23°	<u>a</u>	111 CONGRESSIONAL DRIVE	21666		USA	
r dea	In la		13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		
36 afte		If Yes Give			Specific	
Pour Pour	Q D				MUT	
15-	ete	(Specify only highest grade completed)	Give kind of work done during most of work	ing 16	ib. Kind of Business/Ind	lustry
within the same of	J W	Elementary/Secondary (0-12) College (1-4or 5+)	,		OUN HOME	
Hygied Ant.				e (First, Middle, Ma		
ld be ental		JOHN PELLEGRINI	MADET THE	CHINOIIIX	JA	
shou and M	,-					Code)
Md 2 alth a 27 is 27 is 17 is		MR. PAUL BELL /HUSBAND	11 CONGRESSIONAL DR	IVE, STEV	ENSVILLE,	MD 21666
Stan item		comoton	Disposition (Name of I	Date 20	c. Location - City or To	wn, State
Page Page Tent c		Labural 2 Cremation 3 Hemoval from State		LY21,2005	EASTON,	MD
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours alt Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other treumatic event, the Madical Exercit	Side	21. Signature of Funeral Service Licensee	22. Name and Address of Facility FELLOWS, HELFENBEIN 106. SHAMROCK ROAD	& NEWNAM	FUNERAL HOM	ME, P.A.
		23a. Part 1. Enter the disease, or complications that caused the death. Do no				Approximate
Physicia		I Immediate Course (Final		_		Onset and Death
/Medica	ıl	resulting in death)		<i>></i>		
Examine	r	PIIIMONI	TRY HYPERT	ENSI	SN	
n =	Je L	if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):			
scute ind trans	аш	Cause (Disease or injury that initiated events c.				
760, te be exe ysician a ne burial-		Due to (or as a consequence of):			
87 cate t		d				
X 68 sertifical ding phy se as th	₩.				T	
Box eath cert attending for use a	ian	in the past 12 months?				*
	ysic	Tes 2000	5 Uther (specify)		188.5	
that the detail	H.	Part II. Other significant conditions contributing to death but not resulting in t	the underlying cause given in Part I.	23e. Did tobac	co use contribute to the	e cause of death?
Division of Vital Records, P.O. for attending Physician: The law requires that the datler death. Director: Atten this certificate has been signed by the linby the funeral director, page 2 should be detached	d b		4 PAILURS	1 ☐ Yes	2 □ No 3 □ Proba	ably 4 @ Unknown
W req	ete			24a Wasan	24h Ware suton	sev findinge available
Re la he la he la he la ha s	Ĕ			autopsy performe	prior to con death?	pletion of cause of
tal		25. Was case referred to medical	00 80 40		No 1 ☐ Yes	2 47 No
Vil reicie	To B		Othor		e 6 □Other (Specify	
Physer this eral of		27. Manner of Death 28a. Date of Injury 28b. Tir	me of 28c. Injury at	28d. Describe how		/
inding R. After	at o	1.■ Natural 5 □ Pending (Month, Ďaý Year) Inj 2 □ Accident investigation	ury Work? M 1 ☐ Yes 2 ☐ No			
Attended of the by the	1100	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Stree	at and Number or Rural	Route Number,
Div	Certification;	4 Homicide building, etc. (Specify)		City or Town, S	State)	
Dir Hospitel or 24 hours after Funerel Dir letely filled in letely	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, 2 Madical Examinar: On the basis of examination and/and manner stated.	death occurred at the time, date and place, or investigation, in my opinion, death occurr	and due to the caus ed at the time, date	se(s) and manner as sta and place, and due to	ated. the cause(s)
To the I within 2- To the I complet	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, E	Day, Year)
1 2 5		2 sick (Vendendom	1 1735048	3 7	118/7.60	5
		30. Name and address of person who completed cause of death (Itym 23a) (T	ypo, Print)		LULUC	
		EDIC D CICANER MOD 2540 CENTROL	EVILLE ROAD, CENTREV	ILLE, MD	21617	
	tate	24 D-1- (1-4 (44-4- D-14-1-)				······································
Regis	trar	JUL 19 2005	Speaker			

-	•		State of Maryland / Department of		giene
			Amend item # 19b per fh/wichd/6-20 Costilique of	Death	Reg. No.2 115 25265
	Discolati		Decedent's Name (First, Middle, Last)	2. Dete of Dec	Day Year
	Physici /Medio		EVELYN MOERE BLOOM	July 4	19 2005 1255
7	Examir		4a Fecility Neme (If not institution, give street and number)	4b. City, Town, or Location of Death	
			DEERS HEAD HOSPITAL CENTER	SALIS BURE	<u> </u>
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yea Months Days	Hours Min. (Month, De	th 9. Birthplace (State or Foreign Country)
1	Director		135-26-2901 96 ""	Sept.1	2 1908 Connecticut
	pue *		Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location		10d. Inside City Limits
	denyi	ō	Maryland Wicomico Salisbury		1 ☐ Yes 2 📉 No
	the the	Director	10e. Street end Number 10f. Zip Code		10g. Citizen of Whet Country?
	with weight		1401 Upland Drive 218		U.S.A
	Jeath 2	Funeral	11 Marital Status 12. Wes Decedent Ever in U.S. 13. Was Decedent of	Hispenic Origin? (Specify Yes or No.	- 14. Race - American Indian,
0	72 hours eftar death with the Merylend nature!', or Neme 23a or 28e-f ehow deal Examiner must be notified at		Armed Forces? If Yes, specify Cul	pen, Mexican, Puèrto Rican, etc.) Specify:	Black, White, etc.
20	72 hours naturel',	1 by	3 MWidowed 4 Divorced Year or Detes:	ороспу.	Specify: Black
5	72 h	Completed	15. Decedent's Education 16a. Decedent's Usual Occu (Specify only highest grade completed) (Give kind of work done	pation during most of working ed)	16b. Kind of Business/Industry
121	within ene. then '	d d	Elementary/Secondary (0-12) College (1-40f 5+)		Name
2	P P P	ပိ	5+ Registered 17. Fether's Neme (First, Middle, Last)	18. Mother's Name (First, Middle,	None
Maryland 21215-0020	2 T D >	B	Unknown	Martha Brinn	·
<u> </u>	should ind Man marke umartic	မ		at and Number or Rural Route Number	
Z	trau			271 W.Palm Bea	ET .
ē,	Hea Hem other		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State
9	Pages nent of int: If Its iry or o		1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Hamden Plains		Hamden, CT.
Baltimore,	in partir a			Funeral Home	namach, cr.
ä	Ded of P		The street of th	Rd.Salisbury,	Md.21801
			23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart fillure. List only one cause on each line.		
1	Physician		shock, or heert vilure. List only one cause on each line.		Onset and Death
4	/Medical	П	Immediate Ceuse (Final disease or condition resulting in death) e. CONG-ESTIVE HEY	FAILURY	E 24 days
	Examiner		Due to (or es a consequence of):		
	P #	Examiner	ARTERIO SCLEROTIC	CARDIOVASO	w/AR yre
	iceta be executed physicien and s the burial-trensit	Каш		DISEA	15E
60,	cien burial		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury		
68760,	physi s the	edical	that initieted events resulting in death) Lest Due to (or as a consequence of):		
_	± D 6		d		
Вох	eeth certif ettending I for use a	Physician/M		1	1
P.0.	t the de by the e tached i	ys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause g	iven in Part I. 23b. Did t	tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
Ω.	es that igned b	by Pt			Tes 2/2/10 SE Probably 4 Olikilowii
rds	n sign			24a. Was	en autopsy 24b. Were autopsy findings available prior to
of Vital Records,	The law requires that the deeth cert ate has been signed by the ettendin page 2 should be datached for usa	Completed		perio	available prior to completion of cause of death?
æ	The ia	E		101	Yas 2 No 1 Yes 2 No
ta		•	25. Was case referred to medical	26. Place of Death (Check only o	
\(\)	Physician: this certific ral diractor,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA O	ther: 4 Nursing Home 5 Resid	dence 6 ☐Other (Specify)
0	ing Ph After th funaral		27. Manner of Deeth 28a. Dete of Injury 28b. Time of Injury 28b. Time of Injury 28c. Inju		how injury occurred
Ö	2 = 0	ğ	2 Accident investigation M 1□	Yes 2 No	
Division	or Attendation of the Cor.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (5 City or Tox	Street and Number or Rural Route Number. wn, State)
	urs al	3	On the state of th		
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier (Check only one) Medical Examiner: On the basis of examination end/or investigation, in my end manner stated.		
	To the within 2 To the comple	N N	ord marrier states.	se number	29d. Date signed (Month, Day, Year)
	- × - ō	N	No Same Com Com To	33900	July 19, 2005
	2 13	4	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		0-1
	MC	7	VIRGINIA A. DULANUMDEMD YOL	XX 2018 SAL	July 19, 2005 15 BURY Md 21802
	Sta	te	31. Dete filed (Month, Day Year) 0 2005 32. Refistrar's Signature	onti-	
1	Registr	10000	DULGULOUS John D. Sparke		

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

		For State		State o	f Marylan		artment			and M		giene	១០១	2	500	2 7
		1. Decedent's Name	(First, Middle, L	ast)			incate	01 2	Julin		2. Date of De	ath	000		3. Time of I	Death
Physi /Med		Willis H	osfeld 1	Buers							July	1 <i>6</i>	200°	ar 2	2:20 1	РМ
Exam		4a. Facility Name (II	not institution, g	ive street and nur	nber)		4b. City, 1	Town, or	Location o	f Death			County of E			
		3515 A B					Stre		H Deden	0411:			rford			
Funera		5. Social Security N		Sex 1X M 2□F	7. Age (In yrs. I	ast birthday) 85 Yrs.	If Under Months	Days	Hours	Min.	8. Date of Bir (Month, Da April	y Year)	20 9.	Birthplac Country	PA	Foreign
Directo		172-05-47 Usual Residence of				0.7					Арии	5,172	20		r A	
nyianc how		10a. State	10b. County		10c. City	y, Town or Lo	cation							10d.	. Inside City 1 ☐ Yes	
8a-f s	Funeral Director	MD	Harfo	rd	St	reet	1									2.A NO
with II	ā	10e. Street and Nur	Burkins	Dood			10f. Zip	154				-	zen of What	Country	(
leath ns 23	era	11. Marital Status	bulkens	12. Was Dece	edent Ever in U.	S. 13.			spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)	<u>us</u>	SA 14. Race - A	merican	Indian,	
after d	Fun		ed 2 Married	Armed Fo	2 🗆 No	i	lYes, spec 1 □ Yes 2		n, Mexican Specify:	, Puerto I	Rican, etc.)			Vhite, etc		
if is 15-10-0050 filed within 72 hours after death with the Maryland Hygiene. ther than "neturel", or items 23a or 28a-f show ant, the Medical Examinar must be notified at	d by	3 Widowed	4 Divorced	If Yes, Giv Year or D	ates: WW I	1							Specify: U			
72 h	lete	(Spec	15. Decedent's ify only highest of	Education rade completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	l Occupa rk done d	ation <i>furing</i> most	t of worki	ng	16b. Kir	nd of Busine	ess/Indus	stry	
withir than	Completed	Elementary/Seco	ndary (0-12)	College (1-4or 5+)		ort D					DA	istrik	outor	ı.	
If y all to Z I Z I 3-0030 should be filed within 72 hours after death with the Maryla of Mental Hygiene. marked other than "neturel", or flems 23a or 28a-f shot matic event, the Medical Examinat must be notified at	(U)	17. Father's Name	First, Middle, La	st)					18. Mothe	r's Name	(First, Middle	, Maiden .	Sumame)			
aryiario should be fil ind Mental H marked oth	ToB	Willis	E. Byer	5		,			Nel	lie_	Hosfel	d				
E 00 20 CO.		19a. Informant's Na	· ·								I Route Numb			te, Zip Co	ode)	
ore, Maryle as 1 and 2 should of Health and Mer litem 27 is marke rother traumatic		Jeanett 20a. Method of Disp	e Byers	/wife	20b. P	lace of Dispo emetery, crei	5 A B	<u>wrki</u> 1e of			Street		2113 cation - City		n. State	
ages intofin t: if it		1 X Burial 2		Aemoval from						17-21	-2005					
Dallimore permit. Pages 1 Department of He Importent: If iten	once.	21. Signature of Fu	-		/.	22	2. Name an	d Addres	s of Facilit	Y R.T	. Foar	d Fur	reral	Home	2, P.A	۷.
U 405 #	a	23a, Parti, Enter t	and I	Gor	rofie.						, Risi		ın, Ml		911 pproximate	
		shock, or hea	rt lailure. List on	ly one cause on	each line.	, ,					i respiratory a	11631,		l In	terval Betw Inset and D	veen
Physicia /Medica		disease or condition resulting in death)	n	a	(or as a conseq	-	der	6	an co	~					zye	ary
Examine				_ Due to	(01 43 4 0011304	derios ory.										
P ==	ner	Sequentially list co if any, leading to in cause. Enter Under	nditions, nmediate sriving	Due to	(or as a conseq	uence of):										
ecuter and -trans	Examiner	cause. Enter Under Cause (Disease or that initiated events resulting in death)		c	(or as a conseq	unana att:								-		
ate be executed hysician and the burial-transit	ical E	1000000		Due to	(or as a conseq	derice or).										
OX 68 / 60 certificate be iding physicial				d												
BOX OR eath certific attending p	Physician/Med	IF FEMALE: 23b. Was deceden in the past 12			tcome of pregna		⊒Ectopic pr	egnancy				2	23d. Date of Month	delivery Da	av Y	'ear
. 0 0 0	ysic	1 ☐ Yes 2[9 ☐ Unknown	□No	4∐Preg	nant at time of d	leath 5[Other (sp	ecify)								
P 2 2 -	by Pr	Part II. Other signi	ficant condition	s contributing to d	eath but not res	sulting in the u	inderlying c	ause give	en in Part I		23e. Did	tobacco u	se contribu	te to the	cause of de	eath?
w requires to been signed should be											1 🗆	Yes 2	No 3[Probab	ly 4 □U	Inknown
ecc law re as bec	Completed										24a. Was		24b. Wer	e autops	y findings a	available ause of
The The page	Com										perfe	ormed? 2 ₭ No	deal			
Of Vital H Physician: The this certificate b	B e	25. Was case relei examiner?	red to medical	Hospital:				Oth	05		(Check only					
Phys this	- To	1 ☐ Yes 2 🔀		28a. Date	Inpatient 2 of Injury	ER/Outpatie			4 🗆 140		me 5. Res 28d. Describe			Specify)		
C g and	tlon	1 XNatural 2 ☐ Accident	5 Pending investiga	(Mor	nth, Day Year)	Injury	М	28c. Injun Worl 1 □	k? Yes 2□				,			
DIVISION I or Attending after death. Director: Afte	ertification:	3 Suicide	6 Could no determin	ad 289. Place	e of Injury - Al h	ome, larm, st	reet, lactory	y, office			281. Location (Street and		r Rural F	Route Numi	ber,
Itel or Itel or Itel or Itel Oil	Cert	4 Giromorda			ing, etc. (Opecin								,			
DIVISION To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one)	1 (X Certifying 2 ☐ Medical Ex	Physician: To the transfer: On the transfer and man	e best of my kno pasis of examina nner stated.	owledge, dear ation and/or in	th occurred ivestigation	at the tin	ne, date ar pinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s) date and	and manne I place, and	or as state due to th	ed. ne cause(s))
To the within To the	₹	20h Sizostura and	title of certifier				290	c. Licens	e number			29d. Dat	e signed (A	fonth, Da	y, Year)	
		1/3	achor	Constan		M.D.		D	004	7813	3	J	ely 1	8	200	5
5+14	7	30. Name and add	ress of person w	no completed cau	520	m 23a) (Type Wyper	Print) Le	sapo	alce	Dr.	suitz	219	Ber	Air	'OM	21014
367	State istrar	31. Date liled (Mor	nth, Day, Year)	feere 32. 1	Registrar's Signa	ature	,									
DUMU 17 C	4/0004	JUL	ע ע עטעט	place	2 15	7										

AROLI	BUSSE	Y 	- State Unpend Item Registrar		Maryland per me (d / Depa G 846 8	artment o	Health Deat	and M	ental Hy	giene Reg. No. 2	005	25259
	Physici	an	1. Decedent's Name (First, Middle, La Harold Perry		OM					2. Date of De Month	Day	Year	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, giv PRINCE GEORGES H	e street and nun	nber)		4b. City, Tow CHEVE	n, or Locatio	n of Death	JULY		005 INCE G	0225 A M EORGES
5/0	, Funeral Director	9	370-00-1471	M 2 F	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Ye Months Da		er 24 Hrs. Min.	8. Date of Bir (Month, Da June 1	th ly, Year) .5, 196	Cour	olace (State or Foreign ntry)
9	Aaryland 1 ehow	ō	Usual Residence of Decedent 10a. State 10b. County DC			n, Town or Lo						1	0d. Inside City Limits 1X Yes 2 □ No
	or 28a-1	Director	10e. Street and Number		was	iiiiigtt	10f. Zip Cod	е			10g. Citizen	of What Cour	ntry?
	23a c		411 Trindad Ave.	NE			200					ed Stat	es
036	s within 72 hours after death with the Maryland iene. Than "natural; or Items 23a or 28a-f ehow the Medical Exemilier must be multiled at	by Funeral	11. Marital Status 1 ↑ Never Married 2 ↑ Married 3 ↑ Widowed 4 ↑ Divorced	12. Was Dece Armed For 1 Tyes If Yes, Giv Year or Da	2 NO No		Was Decedent f Yes, specify (1 ☐ Yes 2 汉			ocify Yes or No Rican, etc.)		Race - Americ Black, White, ecify: B1a	etc.
Maryland 21215-0036	within ane. than *	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		-4or 5+)	(Give life.	dent's Usual Od kind of work do DO NOT use re	ne during m tired)		ng		of Business/In-	,
d 2	e filed at Hygic other vent,	0	17. Father's Name (First, Middle, Last,)		_ II alis	portat:			(First, Middle		overnme	ent
ylar	should be ind Mental I marked o	ToB	Rufus Bussey					Haz		Hall			
Mar	d 2 sh th and 7 Is m treum		19a. Informant's Name/Relationship (Rufus Bussey /	_{Туре, Print)} ′ Father			ng Address (Str . Trind a				-		Code)
Baltimore,	Pages 1 and 2 should be filed vant of Health and Mental Hygies at: If Item 27 Is marked other ty or other treumatic event, It	0 1)	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		State	ace of Dispo	sition (Name o natory or other	place)	D	ate	20c. Locati	on - City or To	own, State
Baltiı	permit. Page Department of Important: If eny Injury or once.		21. Signature of Funeral Service Lice	*)	22 A	Name and Ad 1exande 1617 Per	dress of Fac	ope Fi	ıneral	Homes		
	Physician // Medical Examiner prize	ledical Examiner	23a. Part1. Wher the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Ather Due to (or as a consequence as a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a conseq	ptic C wence of):							Interval Between Onset and Death
P.O. Box 68	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live b	come of pregnar irth 2 Fetal ant at time of de own	death 3[Ectopic pregna Other (specify				23d.	Date of delive Month	ery Day Year
rds, P	w requires thet been signed by should be deta	ρ	Part II. Other significant conditions of	contributing to de	eath but not resu	ulting in the u	nderlying cause	given in Pa	rt I.	23e. Did 1	1/		ne cause of death?
l Reco	The law re cate has bee page 2 sho	Completed				-					an 24 osy ormed? 2 No	death?	psy findings available mpletion of cause of 2 No
Vita	ysician:] is certifical director, p	Be	25. Was case referred to medical examiner?	Hospital:	37			Othor		(Check only			
of	g Physics this seral di	n: To	1 X Yes 2 No 27. Manner of Death	1 1 1	npatient 2 🔼 of Injury h, Day Year)	ER/Outpatier 28b. Time of Injury	nt 3□ DOA 28c. I	njury at Work?		ne 5 Resi 28d. Describe			y)
Division of Vital Records,	or Attending I fler death. Director: After In by the funer	Certification:	1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be determined	e 28e. Place	of Injury - At ho	me, farm, str	М	1 Yes 2		28f. Location (City or To	Street and No	umber or Rura	al Route Number,
	To the Hospitel or Al within 24 hours after of To the Funerel Direc completely filled in by	edical Ce	2.43 Cartifying F1 (Check only one)	nysician: To the niner: On the ba and mans	asis of examinat	wtadge Jaat ion and/or in	h occurred at the vestigation, in r	e tima, data ny opinion, d	and place t	and due to the ed at the time,	cause(s) and date and pla	I marrier as st ce, and due to	tated, o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	hel completed caus	Kull	(M)	0.	.C.M.E		-1000000	29d. Date sig	gned (Month, Y 17,	Day, Year) 2005
CA			YARGARITA	A.KOR	.CU111	PENNN	STREET	BALT	IMORE,	, MARYLA	ND 212	.01	
	Sta Regist		31. Date filed (Month, Day, Year) JUL 2 6 200	5 Jan	egistrar's Signat	ture And	de						

			State of Maryland / Department of Health and Men	tal Hygier	e	
			1- State Regis MEND#9,13,20b/c/,22perFH7/18/05,FM,MCertificate of Death	Reg. N	2005	25269
	Physici	_		Date of Death Month D	ay 2005	1.03 Am M
	/Medic Examin	8.00	4a. Facility Name (If not institution, give street and gumber) 4b. City, Town, or Location of Death	4	c. County of Death	
100	Funeral	Mary 1	5. Social Security Number 6. Sex 7. Age (In yrs. Jast birthday) If Under 1 Year If Under 24 Hrs. 8. D	Date of Birth	9/ Birth	place (State or Foreign
100	Director		099 - 12-610/ 10 M 20 F 82 Yrs. Months Days Hours Min. 6	Month, Day, Yea	977 U COU	York
	/land low		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Ba-f sh	ctor	mb Montgomery Solverspring MD.			1 1 1 1 1 1 1 No
	with th	Funeral Director	100. Street and Number 100. Zip Cpde	10g. (Citizen of What Cou	intry?
	ems 2;	ınera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Armed Forces?)	Yes or No-	14. Race - Ameri Black, White	
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examinat must be notified at once.	by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes 3 No If Yes 2 No Specify: Puer to Rica Puer to Rica		Specify:	usacia-
5-0036	72 hou	eted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during must of working life. DO NOT use retired)		Kind of Buriness/Ir	
2121	filed within Hygiene. ther then "	Completed	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)		NIA	
	be filed stal Hyg ed other	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (Fin	rst, Middle, Maid	en Sumame)	Hart
aryland	should I nd Meni marked	일	19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Roi	ute Number Cin	or Town State Zi	n Code)
≥	1 and 2 shu Health and Iem 27 is m		Lark Bergwin Anderson 10213 Menlo He	Siver	Spring,	MS 20910
ore	Pages 1.8		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cometany, crematory, or other place) 20c. Place of Disposition (Name of cometany, crematory, or other place) 20c. Place of Disposition (Name of cometany, crematory, or other place)	7-10-05	${ m Lie}$ tion . City or T ${ m Lie}$	own, State
Baltimore,	permit. Pag Department Important: f any injury o		21. Signature of Funeral Service Licensee Moo382 22. Name and Address of Facility	1, 3	7000	Total .
ä	Depa Impo any ir		NTWILL NATURALLY RAPP Funeral & Cremation	on Serv	ices	1/10
			23a. Part1. Enter the disease, or complications that caused the death. Do not also the death of the part of the pa	Mirat Dires III	g, MD 20	9Approximate Interval Between Onset and Death
1	Physician /Medical		timediate Cause (Final disease or condition resulting in death) Alzheimer's Dementiq Due to (or as a consequence of):			20 years
	Examiner	. _	Successfieldy list conditions but any, leading to immediate Due to (or as a consequence of):			
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
8760,	tate be executed obysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):			
	ficate t physical as the t	edical	d			
Box 6	Attending Physician: The law requires that the death certificate be executed robath. robath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of deliv	rery Day Year
P.0.	the deay the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 ☐ Other (specify)			July 104
	es that igned b	by Pł	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			the cause of death?
ord	w requir been si should	eted		1 🗆 Yes		bably 4 □Unknown
Rec	The taw te has age 2 s	Completed		24a. Was an autopsy performed? 1 ☐ Yes 2 Ø?	prior to co	opsy findings available ompletion of cause of
/ital	ysician: The is certificate hadirector, page	Be	25. Was case reterred to medical axaminer?		40 10163	20110
of	Physi or this o	. To	1 Yes 2 Mo 1 Yes 2 Mo 27. Manner of Death 1 Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Date of Injury 28b. Time of Injury 28c. Injury 28d.	5 Residence		ify)
sion	ending Physath. or: After thi	atlor	2 Accident investigation M 1 Yes 2 No			
Division of Vital Records,	l or Att after de Direct	Certification:		Location (Street City or Town, St	and Number or Rui ete)	ral Route Number,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier (Check only (Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at	due to the cause	(s) and manner as	stated.
	thin 24 thin 24 the F emplete	Medical	29b. Signature and title of certifier 29c. License number		Date signed (Month)	
)	F 3 F 8		DS896Z		4.7	•
	V		030 162		ナーナーノン	25
	V		30, N me and address of person who completed cause of death (Item 23a) (Type, Print)	201 Dack	7/7/200	20050
	V	ate		300 Rock	ville MD	20850

		30. Name and address of person who	completed cause of	death (Item 23	a) (Type F		7		July	18, 20	000
- 100 - 100		29b. Signature and title of certifier	ile . /			29c. License				te signed (Mont	
To the Fu	Medical	one)	niner: On the basis of and manner s	of examination	and/or inv	estigation, in my op	inion, death occ	urred at the time,	date and	d place, and due	to the cause(s)
To the Funeral Director: completely filled in by the	al Certific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined	building, e	tc. (Specify)	dge, death	et, factory, office	e, date and plac	City or To	wn, State	and manner as	ural Route Number,
After this funeral dir	Certification; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		urv 28b	Outpatient Time of Injury	28c. Injury Work	4 Iduising	Home 5 Resi			Assiste
ate has page 2	Be Completed	25. Was case referred to medical examiner?					26. Place of De	24a. Was auto perfet 1 Tyes eath Check only	psy omed? 2 X No	prior to death?	utopsy findings avai completion of cause : 2□ No
5 6	þ	Part II. Other significant conditions of Severe Dements		but not resulting	g in the un	derlying cause give	n in Part I.	1 🗆	Yes 2	X No 3□Pr	o the cause of death robably 4 □Unkr
by the attending ached for use as	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	2 Fetal death	ath 3□ n 5□	Ectopic pregnancy Other (specify)				23d. Date of de Month	livery Day Year
physician and s the burial-transit	Physician/Medical Examiner	if any, leading to immediate cause. Enter Undertying Cause. Enter Undertying Cause. (Literate of pury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d.									
sician edical miner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	aPneumoi								Onset and Deal
lmpo any ir		23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	ed the death. D	11		Hampshir	e Ave Si	<u>llve</u> 1	Spring	Approximate Interval Between
Importent: If item 27 is marked any injury or other treumatic evonce.		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 2) Signature of Funeral Service Lices	y)	3 (Dav	id Memori	al 07/	19/2005	Fa1	ls Chur	
item 27 gther tr		Claire Brown - Da 20a. Method of Disposition		20b. Place		Blueford sition (Name of patory or other place		nsington Date		20895 ocation - City or	Town, State
is marked reumatic ev	2	Don Rosen 19a. Informant's Name/Relationship (Турө, Print)			g Address (Street a		Rural Route Numi			Zip Code)
arked othe	Be	17. Father's Name (First, Middle, Last,)					ame (First, Middle	e, Maider	Sumame)	
other then '	Somp	Elementary/Secondary (0-12)	College (1-4or			keeper	,		Co	11ege	
"nature	Completed	15. Decedent's Ed (Specify only highest gra	ducation		(Give	dent's Usual Occup kind of work done o OO NOT use retired	during most of w	orking	16b. F	Kind of Business	s/Industry
r then "naturel", or items 23a or 28e-f show the Neulcal Examinat must be notified at	by Fun	1 Never Married 2 Married 3 1 Widowed 4 Divorced	Armed Forces 1 Yes 2 N If Yes, Give Year or Dates	?]No		Was Decedent of H f Yes, specify Cuba l □ Yes 2 XNo		erto Rican, etc.)	J.	Black, Whi	ite, etc.
ns 23a must (Funerai	11620 Kemp Mill R	oad 12. Was Deceden	t Ever in 11 S	12 1	20902	ispanio Origina	(Specify Vos. 511)		ted Stat	
or 28e e roll	Director	10e. Street and Number	iery	DILLY	er ob	10f. Zip Code			10g. Ci	itizen of What C	ountry?
-f shov	tor	10a. State 10b. County MD Montgom	1027	10c. City, T							10d. Inside City L
irector		Usual Residence of Decedent		92	Yrs.			07/14/	1913	Po	land
uneral		Social Security Number 6. S		ge (In yrs. last		If Under 1 Year Months Days					rthplace (State or F
Examir	ier	4a. Facility Name (If not institution, give Caring Companion		r)		4b. City, Town, or Silver S		ath		c. County of Dea lontgome	
Physici Medio/		Gertrude Birnba						July	1	7 2005	
		1. Decedent's Name (First, Middle, La	51)					2. Date of D			Time of De

1. For Unpend Item	State of Maryland / Dep 23a&27 per me G846	partment of Health and	Mental Hygien	e
1. Decedent's Name (First, Middle, La		eniircate or Death	Reg. No.	02005 2527
Physician Barbara	Virginia	Burton	JULY 14,	2005 Year 2:37 P M
Examiner 4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dea		c. County of Death
UNIVERSITY OF MAR 5. Social Security Number 6. S	EYLAND HOSPITAL Sex 7. Age (In yrs. last birthda)	BALTIMORE CITY If Under 1 Year If Under 24 Hr		9. Birthplace (State or Foreign
	1 M 2 1 F 8 2 Yrs.	Months Days Hours Mir		Country)
Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or I	ocation		10d. Inside City Limits
10a. State 10b. County 10a. State 10b. County 10a. Street and Number 23 5 0 7 6+ 11. Marital Status		Man		1 Tes 2 Lino
Mult the Market and Number (196. Street and Number 196. Street and N	-	10f. Zip Code	10g. Ci	itizen of What Country?
2350 Po+	12. Was Decedent Ever in U.S. 13	2/676		USA
and the death of the state of t	Armed Forces? 1 ☐ Yes 2 ☑ No	. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	into Rican, etc.)	 Race - American Indian, Black, White, etc.
S S S S S S S S S S S S S S S S S S S	If Yes, Give Year or Dates:	1 ☐ Yes 2 12 No Specity:		Specify: Black
Cod the secondary (0-12)	(Giv	edent's Usual Occupation e kind of work done during most of wi DO NOT use retired)	orking 16b. H	Kind of Business/Industry
C in the secondary (0-12)	College (1-4or 5+)	mestic Wor	Ken Pr	ivate Residence
To be the second of the second			ame (First, Middle, Maider	
	IWIN Brook		nche Pa	IMer
_ c= % = \ \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	rooks 125	ling Address (Street and Number or F Putnam AVE	2.1	11 11
1 Purial 2 Cromption 2	20b. Place of Disp			ocation - City or Town, State
20a. Method of Disposition 1 Disposition 1 Disposition 1 Disposition 1 Disposition 1 Disposition 21. Signature of Funeral Service Licer	v) St. John	Cemetery 7/	20/05 W	Hman, Maryland
4 Donation 5 Other (Specification of Specification of Spe	or of the second	22. Name and Address of Facility HENRY FUNERAL	Home, P.A.	1 10 01/13
23a. Part 1. Enter the disease, or com	plications that caused the death. Do not er	10 Washington	St. Cambr	Approximate
shock, or heart failure. List only Immediate Cause (Final disease or condition	Exsanguination Due	To Lower Gastroin	ntestinal He	Interval Between Onset and Death
/Medical resulting in death) Examiner	Due to (or as a consequence of):			
Soquentially liet conditions, if any, leading to immediate	Due to (or as a consequence of):			
ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С.			
	Due to (or as a consequence of):			
ohys die dic	_ d			
The past 12 months?	23c. If yes, outcome of pregnancy	50.		23d. Date of delivery
O a contract of the past 12 months? I Dyes 2 DNo O D D D D D D D D D D D D D D D D D D		☐Ectopic pregnancy ☐ Other (specify)		Month Day Year
C a D D Part II Other eignificant conditions o	ontributing to death but not resulting in the	underlying cause given in Part I	23e Did tobacco	use contribute to the cause of death?
S Part II. Dther significant conditions of		undonying dadd given in raich.	1 ☐ Yes 2	- \
al Record The law requir cate has been si page 2 should Completed			24a. Was an	24b. Were autopsy findings available
The Table has page			autopsy performed? 1 2 Yes 2 No	prior to completion of cause of death? 1 ☑ Yes 2 ☐ No
After this certificate has been signed through the conditions of t	Hospital: 🚁	04	ath (Check only one)	
O sign of D 12 Manner of Death	28a. Date of Injury (Month, Day Year) 2 ER/Outpatie 28b. Time Injury		Home 5 Residence	
27. Againter of Death 14. Natural 5 Pending 2 Accident investigation		of 28c. Injury at Work? M 1 Yes 2 No		,, , , , , , , , , , , , , , , , , , , ,
DIVISION Teal or Attanding Physical Control of the following the following physical or Attanding Physical or Attanding Physical or Attanding Physical or Attanding Physical or Attanding Physical Origin	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number,
29a Certifier 1 Certifying Ph	veicing: To the best of my knowledge, dee	th	- 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	
29a. Certifier 1 Certifying Phones 1 Certifying Phones 29a. Certifier 2 Medical Examone)	ysician: To the best of my knowledge, dea niner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and plac nvestigation, in my opinion, death occ	e, and due to the cause(s) urred at the time, date and) and manner as stated. d place, and due to the cause(s)
d not not not not not not not not not not	niner: On the basis of examination and/or ii	29c. License number	urred at the time, date and) and manner as stated. d place, and due to the cause(s) te signed (Month, Day, Year)
29a. Certifier 1 Certifying Phone 2 Medical Example 1 Certifying Phone 2 Medical Example 29b. Signature and title of certifier	and manner stated.	29c. License number OCME	urred at the time, date and	d place, and due to the cause(s)
29a. Certifier 1 Certifying Phone 2 Medical Example 1 Certifying Phone 2 Medical Example 29b. Signature and title of certifier	and manner stated. (M) (M) (Type completed cause of death (Item 23a) (Type	29c. License number OCME	urred at the time, date and	d place, and due to the cause(s) te signed (Month, Day, Year)

			1 - For Stete Registrar		Maryland	-	artment rtificate					Reg. N	00	0.5	25272
	Physici	an	Decedent's Name (First, Mide	_							2. Date of Month		ay_	Year	3. Time of Death
	/Medic	al	David	Bonar	Ве	11	1 n on T	. 0	1	(Dank	July				11:55P M
	Examin	er	4a. Facility Name (If not instituti				4b. City, T			or Death		1		y of Death	1
	Funeral		Ginger Cove He 5. Social Security Number		T. Age (In yrs. I	ast birthday	If Under 1	Year	olis If Under		8. Date of (Month,			9. Birthi	lde1 place (State or Foreign ntry)
ы	Director	4	235-62-7932	1 ∑ M 2□F	91	Yrs.	Months	Days	Hours	Min.	Nov. 1				h Dakota
	D >		Usual Residence of Decedent 10a. State 10b. Coun		10a Cib	, Town or L									
	shov	5													10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	Directo	Maryland Anne	Arundel	£	nnapo	10f. Zip (Code.				100.0	`itizen of	What Cou	
	With Ba or		8111 River Cr	escent Driv	7.0		101. 210	214	Λ1			-		Stat	•
	ms 23	Funeral	11. Marital Status	12. Was Dece	dent Ever in U.	S. 13.	Was Decede			gin? (Spe	cify Yes or		14. Ra	ce - Ameri	can Indian,
9	or ite	Fur	1 Never Married XXM	Armed For 1X Yes If Yes, Give	2 No 10 2	7-	1 Tes, specif	_	n, Mexicar Specify:		Rican, etc.)			ick, White,	etc.
21215-0036	within 72 hours after death with the Maryland nne. than "netural; or items 23a or 28e-f show in Medical Examination in Mille Jat	d by	3 Widowed 4 Divorce	Year or Da			11105 2	1 00	эрөспу.				Specif	w: Wh	ite
<u>7</u>	"net	Completed	15. Decede (Specify only high	ent's Education lest grade completed)		(Give	edent's Usual s kind of work DO NOT use	done di	urina mos	t of worki	ng	16b.	Kind of B	Business/In	dustry
12		d m	Elementary/Secondary (0-12)	College (1-	-4or 5+)		r Admi					IIG	Navy		
9	Hygi Hygi ther		17. Father's Name (First, Middle			200	I II GIII I		18. Mothe	er's Name	(First, Midd				
an	od ala	o Be	William Bo	nar B ell					Clar	a Pr	eston				
Maryland	d 2 should th and Men 7 is marke traumatic	-	19a. Informant's Name/Relation	nship (Type, Print)		19b. Mail	ing Address (Street a	nd Numbe	er or Rura	l Route Nur	nber, City	or Town	, State, Zip	Code)
	C = 0 -		Margaret Bell	/ Wife	, i		River					7			
Baltimore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	n 3 □Removal from S			osition (Name matory or oth				ate	20c.	Location	- City or To	own, State
Ë	permit. Pag Department Important: i eny injury conce.		4 Docation 5 □ Other		Bal		e Crem								Maryland
Bal	permit. Pag Department important: i eny injury o once.		21. Signature of Funeral Service	S. Juy !	or	14	7 Duke	of	Glou	cest	er St	. , A1			1 Home, Inc MD 21401
			23a. Fart1. Enter the disease, shock, or heart failure. Li	or complications that ca st only one cause on ea	aused the death ach line.	i. Do not en	iter the mode	of dying	, such as	cardiac o	r respiratory	arrest,			Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_aCa	n die	me	1000	atl	14						Hours
	/Medical Examiner			Due to (or as a consequ	ience of):	741	e 02	0-6	700	osis				
		ē	Sequentially list conditions, if any, reading to immediate	b. Due to (c	المالات ما مه ده ال	o of):	The	70	ے کی در		د ار				Jeans
	be executed sician and burial-transit	Examiner	ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1 Atr	rial	Fi	bai	110	atic	m					Y-Pan &
o o	be executed ician and burial-transit		resulting in death) Last	Due to (c	or as a consequ	ience of):									
8760,	ate be exe hysician a the burial-	lical		d											
9	death certificate e attending phys of for use as the	Physician/Med	IF FEMALE:	220 H una nute	tomo el progra		1000								
Вох	attend for us	lan	23b. Was decedent pregnant in the past 12 months?		irth 2 ∏ Fetal ant at time of de	death 3	Ectopic pre							ate of delive onth	ery Day Year
o.	at the de by the a stached	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno		34 111 51	_1 Other (spec	ciiy)				-			
٩	de eg	by Pr	Part II. Other significant condi	tions contributing to de	ath but not resu	ılting in the u	ınderlying ca	use give	n in Part I.		23e. Di	d tobacco	use con	tribute to t	he cause of death?
Records,	w requires been sign should be										1 [Yes	2 No	3 Prot	oably 4 □Unknown
000	aw re	plet									24a. W				ppsy findings available
H.	he e h	Completed									pe 1 Tyes	topsy rformed? 2 X N		death?	mpletion of cause of 2 No
Vital	ician: T certificat rector, pa	Be (25. Was case referred to medic examiner?	cal					26. Place	of Death	(Check onl	$\overline{}$			
of \	Physician: this certific ral director,	은	1 ☐ Yes 2 XNo			ER/Outpatie		-			ne 5□Re				y)
n	ling After Tune	lon	27. Manner of Death 1 Natural 5 Pend	9	of Injury h, Day Year)	28b. Time of Injury	of 28	lc. Injury Work	at ? ′es 2 □ l		28d. Describ	e how in	ury occur	rred	
Division	tor: the	lical	3 Suicide 6 Coul		of Injury - At ho	me, farm, st			62 5 T		28f. Location	(Street	and Numi	ber or Run	al Route Number,
Ω	al or Al s after o il Direct od in by	Certification	4 Homicide dete	mined 200. Face buildin	ng, etc. (Specify	")	,,	0.1100			City or 1	rown, Sta	ite)		
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in E	edical C	29a. Certifier 1 Certify (Check only one) 2 Medica	ring Physician: To the al Examiner: On the ba and mann	isis of examinat	wledge, dea ion and/or in	th occurred a rvestigation, i	t the time	e, date an inion, dea	d place, a	and due to the	ne cause e, date a	(s) and mand place,	anner as s and due to	tated. o the cause(s)
	To the To the To the Comp	Me	29b. Signature and title of certif	ier	00:	400			number	00		29d. E	ate signe	ed (Month.	Day, Year)
•			Kakes	in aro	Na	עוין	-	$\nu 2$	101	08			1/11	100	
			30. Name and address of person Rakesh Arora,					Sui	ite 2	22.	Bowie	, MD			
	Sta	ite	31. Date filed (Month, Day, Yea	r) 32. P	gistrar's Signat	ture	Taray .				;				
	Registr	ar	JUL 1	± ₹000	More ,	OF 1	books	•							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2005 **Physician** July 28, 3:50 A M Lucy Rose Cullum /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Memorial Hospital 7. Age (In yrs. last birthday)

Q 2 Yrs. Months Days Hours Min. 09/02/1921 Havre de Grace Harford 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1□M 2□XF Director 215-18-3742 Maryland Usual Residence of Decedent 10a. State 10b Counts 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Maclical Examinar must be multiled at 1 Yes 2 □ No Director Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 455 Wye Drive 21001 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 → No à Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7; th and Mental Hygiene. 7 is marked other than "no Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Civil Service Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Antonia Acocella Adam DeMarco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 108 Lincoln Avenue, Elkton, MD 21921 <u>Betty Buchanan (sister)</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages : Department of H Important: If Ite any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 08/01/2005 Calvary Methodist Ceme. Churchville, Maryland ²². Name and Address of Facility. Tarring—Cargo Funeral Home, P.A. 21. Signature of Funeral Service Lig-23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 333 South Parke Street, Aberdeen, MD 21001 Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician onan disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No Vital 2□ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred **Division**, Hospitel or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerel C to Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and tille of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar DHMH 17 Rev 1/2001 MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12 - Nilhau TD 1106 Revolution St

Wham

31. Date filed (Month, Day, Year) AUG 0 3 2005

D 32609

Have De Grace MD 21078

			For State	State of Marylan				nd Mental Hy	giene		
			Registrar 1. Decedent's Name (First, Middle, L.	ast) C A I I	Ce	rtificate of l	Death	2. Date of De	Reg. No.	2005	25271:
	Physici /Medic		ANNO	ECAHO	>			Month	7/Dey	X Yeer	6:00 A M
L	Examin		4e. Facility Name (If not institution, ga	ive street and number)		4b. City, Town, or	Location of I	Death	4c. C	County of Death	
			Heritage Harbour 5. Social Security Number 6.	Nursing and Re		Annapol If Under 1 Year	is If Under 24	Hrs 9 Oato of Ri		ne Arun	
	Funeral Director		187-18-2205	1□M 2KTF 84	Yrs.	Months Days		Min. 8. Date of Bir (Month, Da Jan. 18	19, Year)	l Nesqu	nplece (State or Foreign untry) uehoning, PA
	pu k		Usuel Residence of Decedent 10a. State 10b. County		y, Town or L	postion		1,555	,		
	Maryla 1 • hor ie 1 • i	ō	MD Anne Ar		evensv						10d. Inside City Limits 1 ☐ Yes 2 No
	or 28a	Director	10e. Street and Number	didet 50	evensv	10f. Zip Code			10g. Citize	en of What Cou	untry?
	ath wit	ralD	101 Baltimore Av	renue		21666			U.S	.A.	
	lterne Items	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin ın, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	D- 14	 Race - Amer Black, White 	
920	within 72 hours after death with the Maryland ene. Than "paturel", or tems 23a or 28a-f ehow the Modical Examinar must be notified at	by	3 \ Widowed 4 □ Divorced	1 □ Yes 2X No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		5	Specify: Wh	ite
2	72 ho natur	Completed	15. Decedent's l (Specify only highest g		16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of	f working	16b. Kind	d of Business/li	
12	within ene. than	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)	1	Presiden			Bank	of Comme	erce
Maryland 21215-0036	should be filed within 72 hours after death with the Marylan to Mental Hygiene. Tarked other than "nature!", or flems 23a or 28a-f show marke other than "nature!" or flems 23a or 28a-f show matte event, the Madical Examinar must be rotified at	Be C	17. Father's Name (First, Middle, Las	it)	,,200			Name (First, Middle	1		
ylar	should bund Menta	To E	Michael Mikulsky	7			Mary	Gayada			
Mar	2 e e		19a. Informant's Name/Relationship					or Rural Route Numb	•		
	tem 27		Michelle Sheehar 20a. Method of Disposition			osition (Name of matory or other place		rensville,		Tand Z ation - City or T	21666 Town, State
altimore,	Pages nent of int: If it iry or o		1 X Burial 2 ☐ Cremation 3 1 4 ☐ Donation 5 ☐ Other (Spec	Chromosa nom State			1	7/21/2005	Ade 1	ohi. Ma	rvland
Balti	permit. Pages 1 a Department of Hec Important: If item eny injury or othe		21. Signa e of F neral Service Lie	Sisee	2	2. Name and Addres	s of Facility	Gasch's F	unera	1 Home,	P.A.
	70 F • 0		23a. Part1. Enter the disease, or con	molifations that caused the death				venue, Hy		ille, M	Saryland Approximate
1	Physician		shock, or heart failure. List ont Immediate Cause (Final	y one cause on each line.	Lin	er the mode of dying	g, such as ca	tolac of lespiratory a	rrest,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a cups-cu	ence f):					-	
	Examiner		Sequentially list conditions,	b. COPI)	(1		. ,			
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	00515	1 /12	in Di	F-Gi	ci/e (0/	175	
o Î	ate be executed thysician and the burial-transit		that initiated events resulting in death) Last	Due to (or as a consequ	uence of):	101-1	/-/-	-//	6 (
8760	death certificate be executed e attending physician and od for use as the burial-transit	dical		d Hype	8+e1	US/0N					
9 X	leath certifica attending pt I tor use as t	iclan/Med	IF FEMALE:	23c. If yes, outcome of pregna	ncv					3d. Date of deliv	
Box	death d for L	iclar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3[Ectopic pregnancy Other (specify)			23	Month	Day Year
о. О	that the de led by the a detached t	Physi	9 Unknown	9∐ Unknown					- Pro-		
d S	8 5 9	by	Part II. Other significant conditions	contributing to death but not rest	ulting in the u	nderlying cause give	en in Part I.	23e. Did 1			the cause of death?
Records,	w require been sig	Completed	Khaboo,	MY0/451	<u> </u>			24a. Was			opsy findings available
	The lay te has age 2	omp		_/_/_				— auto	psy prmed?	prior to co death?	ompletion of cause of
Vital	ysician: The is certiticate hidirector, page	Be C	25. Was case referred to medical examiner?				26 Place of	Death (Check only	2 /A .No	10,103	2 140
	문 등 등	: To	1 ☐ Yes 2 No 27. Nonor of Pean		ER/Outpatie		4 Drivursii	ng Home 5 Resi			(fy)
Division of	ding that that Atter funer	ition	1 Natural 5 Pending 2 Accident investigate	28a. Date of Injury (Month, Day Year)	Injury	Work	val° (? Yes 2 □ No	28d. Describe	now injury	occurred	
N N	or Attenater deat after deat Director: I in by the	ertiflcation:	3 Suicide 6 Could not determine		ome, farm, st	reet, factory, office		28f. Location (City or To		Number or Rur	al Route Number,
	ospital o hours aft uneral Di ly tilled in	O	Continue of Continue of								
	24 de	edical	29a. Certifier Check only one) Certifying P	Physician: To the best of my kno miner: On the basis of examinal and manner stated.	wledge, deat tion and/or in	h occurred at the tim vestigation, in my op	ne, date and pointion, death of	place, and due to the occurred at the time,	cause(s) a date and p	nd manner as s place, and due t	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	Pollant	1	29c. License	number	102	29d. Date	signed (Month.	Day Year)
	1.		1	Jan Ho	10/M	V. DOI	1780	000	0	+/17	105.
11	\cup ψ		30. Name and address of person who	TO SUU III.	23á) (Type,	BUD. S	SUITE	326.51/1	ER SI	PLING.	4020901
	Sta		3. Date filed (Month, Day Year)	32. Registrar's Signa	ture	2,	1/ /				

			For State Registrar	State of M	laryland / Depa Cei	artment of Hea		5000	0.0	trons.
	Physic	ian	Decedent's Name (First, Middle, Las Michael	,				Date of Death Month	Day Yes	6- There of Death
	/Medi Exami		4a. Facility Name (If not institution, give	Eugene	CAVENDER,	SK . 4b. City, Town, or Loc	cation of Death	July 7	4c. County of De	7 -77
	LAdilli	ICI	Washington Count			Hagersto	OF F-1		T71 -2	
	Funeral		5. Social Security Number 6. Se	x 7. A	ge (In yrs. last birthday)		Under 24 Hrs. 8.	Date of Birth (Month, Day, Yeanuary	9. E	Birthplace (State or Foreign
	Director		Usual Residence of Decedent	2 101 2 1	59 Yrs.		Já	anuary l	.2,1946	Maryland
	yland yow		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	e Mar Ba-fel	ctor	Maryland Washingt	on	Hagersto	wn				1X☐ Yes 2 ☐ No
	vith th	Director	10e. Street and Number			10f. Zip Code		10g.	. Citizen of What	Country?
	death with the Maryland ms 23s or 28s-f ehow must be notified at	erai	242 South Mulberr	12. Was Decedent	Everin IIS 13 V	21740	nio Origin? (Specifi	y Von er No	U.S.A.	merican Indian,
	Safter d	by Funerai	1 Never Married 2 Married	Armed Forces	? [No	Was Decedent of Hispar f Yes, specify Cuban, M		an, etc.)	Black, W	hite, etc.
	DO3	d by	3 ☐ Widowed 4 2 Divorced	If Yes, Give Year or Dates:		I□Yes 2⊠ No Sp	pecify:		Specify:	white
	n 72 h	iete	15. Decedent's Ed (Specify only highest grad	ication le completed)	16a. Deced (Give	lent's Usual Occupation kind of work done durin DO NOT use retired)	n ng most of working	168	b. Kind of Busines	ss/Industry
	212 d within giene.	Completed	Elementary/Secondary (0-12) 0-10	College (1-4or	5+)	k driver		1	transpor	tation
	Maryland 21215-0036 d 2 should be filed within 72 hours aft file and Mental Hygiene 171 le marked other than "natural; or traumatic event, the Medical Exami	BeC	17. Father's Name (First, Middle, Last)	-		18.	Mother's Name (F			
	ylal	To 1	Grandvill					Catherin		
	Mar d 2 sh sh and 7 le m traum		19a. Informant's Name/Relationship (T			g Address (Street and I				41/4
	re, s 1 an Healt Item 2		Michael E. Cavend 20a. Method of Disposition	er, Jr	20b. Place of Dispo	sition (Name of	erry Stree		erstown, c. Location - City o	
	Pages nent of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐! '4 ☐ Donation 5 ☐ Other (Specify)			natory`or other place) m Cremator	y July ₂	3 5 на	oerstow	n, Maryland
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Examinet must be notified at once.		21. Signature of Funeral Service Licens	600		. Name and Address of	J		Funeral I	
	O 89 E 2 8		John 18	Keinels						Maryland 2174
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that cause ne cause on each I	d the death. Do not entr ine.	er the mode of dying, su	uch as cardiac or re			Approximate Interval Between Onset and Death
13	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Covona	, y (Ax)	leny	Dise	654	Olisor and Beatin
5	Examiner			Due to (or as	a consequence of):	TIVE H	teart	tailu	1	
	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):		(1			
	ecuter and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence of):	125 M	121,44	5		
	58760, ficate be executed physician and s the burial-transit			Due to (or as	Chrani	c Ren	ial F	ailur	(
ひ	687 ifficate g phys	edicai		d						
5	ds, P.O. Box 6 ires that the death certifi signed by the attending to be detached for use as	Physician/Me	200. Was decedent program	23c. If yes, outcome		Ectopic pregnancy			23d. Date of d	
-	.O. E the dea by the at	/sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□ Pregnant a 9□ Unknown		Other (specify)			Month	Day Year
\geq	that the odd by detac		Part II. Other significant conditions co	ntributing to death t	out not resulting in the ur	iderlying cause given in	Part I.	23e. Did tobace	co use contribute	to the cause of death?
1	ords, requires een sign	ed by						1 🗆 Yes	2 □ No 3 □ I	Probably 4 Dunknown
0)	() > 0 5	Completed						24a. Was an	24b. Were	autopsy findings available
J	Vital Rec	Com						autopsy performed	death?	o completion of cause of ? as 2 \sum No
aveno	of Vital Phyeiclan: 1 this certifical	Be	25. Was case referred to medical examiner?	Hospital:		Other	Place of Death (Ca			
3	on of alling Physics After this funeral dir	: To	1 Yes 2 No	1 Inpatie		28c. Injury at	Nursing Home	5 Residence		necify)
	Vision Attending r death. actor: After	atior	1 Natural 5 Pending 2 Accident investigation	(Month, Da	ay Year) Injury	Work? M 1 ☐ Yes			ijary sosariou	
	Division or Attending after death. Director: After In by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In	jury - At home, farm, stretc. (Specify)	eet, factory, office	28f.	Location (Street City or Town, St	t and Number or I	Rural Route Number,
	oital o			+					ŕ	
	Division of Vital Re To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying Phy (Check only one) 1 Medical Exami	sician: To the best ner: On the basis o and manner st	of my knowledge, death of examination and/or inv ated.	occurred at the time, da estigation, in my opinior	ate and place, and n, death occurred a	due to the cause it the time, date	e(s) and manner a and place, and du	as stated. ue to the cause(s)
	To the Within To the compl	Me	29b. Signature and title of certifier			29c. License nun	. /	, 29d.	Date signed (Mor	nth, Day, Year)
	AB		> famil	~~~	~	000	60394	0 -	7/22	- 105
	2		30. Name and address of person who co	ompleted cause of o	death (Item 23a) (Type, I	Print) //2 (opa	1 ct	1	11742
	Sta	te	31. Date filed (Month, Day, Year)	32. Regett	rar's Signature		Hagirs	Jour,	WD	1110
	Regist		JUL 25	3004	um H. L	ander				

			For State	State	of Marylar		artment of H			~ ~ 4	005	25276
			Registrar Decedent's Name (First, Middle	Loot		Cer	uncate of L	Jeani	2. Date of De.		100	3. Time of Death
4	Physici	an	b .						Month	Day	Year	
	/Medic		George Leroy				41. O'r. T.	1	July		-	6:45 A M
	Examin	er	4a. Facility Name (If not institution		umber)		_	Location of Death	1		ty of Death	
	165		Caroline Nursi 5. Social Security Number	ng Home	7. Age (In yrs.	loot hirthday)	Denton If Under 1 Year	If Under 24 Hrs.	8. Date of Birt			l (0t-t 5i
Ã.	Funeral			1 X M 2□F	101	Yrs.	Months Days	Hours Min.	(Month, Da	y, Year)	Coun	
3 (3)	Director		217-36-1696 Usual Residence of Decedent		101				Feb 11	1904	Mary:	Land
	land ow		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation				1	0d. Inside City Limits
	Many High	to	Maryland Caroli	ina	Go	ldsboro	,					1X Yes 2 No
	1 the	Directo	10e. Street and Number	-110	- 00	IGBDOIC	10f. Zip Code			10g. Citizen o	f What Cour	ntry?
	3a or		501 Old Town R	oad			21636			U.S.A	٧.	
	death with the Maryland rms 23s or 28s-f show	Funeral	11. Marital Status	12. Was De	cedent Ever in L	J.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (S	pecify Yes or No	14. Ra	ace - Americ	
0	r Ita		1 Never Married 2 Marri	Armed fi ed 1 ☐ Yes	2 X No	Ì			o Rican, etc.)	BI	lack, White,	etc.
<u></u>	hours after tural', or its	by	3X Widowed 4 ☐ Divorced	If Yes, C Year or			I□Yes 2X No	Specify:		Spec	ify: Wh	ite
9	72 ho	Completed	15. Decedent (Specify only highes		4 1	16a. Deced	lent's Usual Occupa	ation	kina	16b. Kind of	Business/Inc	dustry
2	filed within 72 Hygiene. other than "nal ent, the Medic	nple	Elementary/Secondary (0-12)		(1-4or 5+)	life. L	OO NOT use retired)	9	0	s 0	
2	or th	Son	09			Forem	an					nty Highway
g	al Hy	Be (17. Father's Name (First, Middle,					18. Mother's Nan			ıme)	
<u>a</u>	should be filed within 72 hours after death with the Marylan nd Mently giene. In marked other than "natural", or Itama 23a or 28a-1 show marked other than "natural", or Itama Le notified at unatic swent. In a Medical Examinar meat the notified at	2	Devolson Cartw	right			-	Virgini	a Monta	gue		
Maryland 21215-0036	Se is		19a. Informant's Name/Relations				g Address (Street a					Code)
	1 and 2 Health Iem 27		Blanche M. Bed	well/ fr		- Annual Control	ain Stree					
ore	of Head		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 Demoval from	n State	Place of Dispo cemetery, cren	sition (Name of natory or other place	9)	Date	20c. Location	1 - City or To	wn, Slate
altimore,	Pages ment of I ant: If it ury or o		' 4 □Donation 5 □ Other (S)			ensbor	o Cemeter	y July	23 200	5 Gree	nsbor	o, Maryland
a	permit. Pages Department of Important: If if sny injury or o		21. Signature of Funeral Service	icensee			. Name and Addres			1 11-	D	
<u></u>	40 F # 9		May (Pla	y	₽ď	eegle ₁₆₀	Greensbo	ein min	21639 nc	me, r	A
1/2			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	t eaused the dea	th. Do not ento	er the mode of dying	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	3h	STANC	tive	Liver	Disc	160			Onset and Death
	/Medical		resulting in death)	Due t	o (or as a consec	quence of):	114(_1				- 1	icheris
ξ.	Examiner		Sequentially list conditions	b								
	D =	ner	if any, leading to immediate cause. Enter Underlying	Due to	o (or as a consec	quence of):						
	nd	Examiner	Cause (Disease or injury that initiated events	c. ====								
Ó,	e exe	Ë	resulting in death) Last	Due to	o (or as a consec	quence of):					111	
8760	The faw requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edicai		d								
9	artific ing p	Mec	IF FEMALE:							2 12	1	
Вох	ath ce ttend or us	an/	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregn birth 2 🗆 Feta	al death 3	Ectopic pregnancy				ate of delive	ory Day Year
0.	the a	sic	1 Yes 2 No	4□Pre	gnant at time of one	death 5⊡	Other (specify)				NOTICE 1	Duy Tour
<u>Ч</u>	that the death certifi ed by the attending detached for use as	Physician/M	Part II. Other significant condition	ne contribution to	dooth but not ro	willian in the w	deskies sauss au	n in Deat I	22a Did I	abassa usa sa	atributa to th	ne cause of death?
ŝ	res tha signed I be del	by	Course significant condition	hoand	1	. a.A.	idenying cause give	mini Faiti.		_/		ably 4 □Unknown
orc	w require been signature	ted	CONGESTIVE	INCAIVI	· all	Ure.				res 22No	3 F100	aciy 4 Dolikilowii
Records,	has b	Completed	Chronic Ri	eval 1	NSUF	Heie	NCY		24a. Was autop	sy	prior to con	psy findings available apletion of cause of
		Son					1		perfo 1 ☐ Yes	med? 2 → No	death?	2 □ No
Vital	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					26. Place of Dea	th (Check only o	ne)		
	Physic this cal	မ	1 ☐ Yes 2 € No			ER/Outpatien		4 Nursing H	ome 5 Resid	dence 6 🗆 O	ther (Specify	1)
u	ng Ph (fter th	 O	27. Mann of Death 1 Shalural 5 ☐ Pendin	28a. Dat (Mc	e of Injury onth, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe i	now injury occu	ırred	
Sio	Attendi death. ctor: A y the fu	cati	2 ☐ Accident investig	ation			M 1 🗆 '	res 2□No				
Division of	iract iract	Certification:	3 Suicide 6 Could n 4 Homicide determ	ined 288. Plat	ce of Injury - At h Iding, etc. <i>(Speci</i>	iome, farm, stri	eet, factory, office		28f. Location (S City or Tox		nber or Rura	l Route Number,
	ital curs af											
	Hosp 4 hor Fune Fune	edical	(Check only 2 Medical	Examiner: On the	basis of examina	owledge, death ation and/or inv	occurred at the time restigation, in my or	e, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and ri date and place	nanner as st a, and due to	ated. the cause(s)
	To the Hospital or Attanding Physician: Within 24 hourst after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Med	опе)	and ma	inner stated.		29c. License			29d. Date sign	·	
	T wi	_	29b. Signature and title of certifier	. 8 (/2	w	7 2	27/		7. Ko	od (Month, t	cuf, ical/
			Jane	2120	رمنع	-11	1/7/	2/6	2	177-	25	
			30. Name and address of person	wno completed ca	use of death (Ite	m 23a) (Type,	Print) Kot	- Ct	Do.	Ition.	, rel	2
	Sta	to.	31. Date filed (Month, Day, Year)	100	Registrar's Sign	ature A	arroc	0	ul	VON	176	Y
	Registr		JUL 2 1	2005	Great A	Age						

			To-	Please							All Copie: Mental H		•	
		1	1 - State Registrar					rtificat				Reg. No		25277
	Physici	an	1. Decedent's Name (F	irst, Middle, Las	1)						2. Date of D			3. Time of Death
	/Medic		Mary Lee C								July	1	•	5 2:30 A ^M
	Examin	er	4a. Facility Name (If no.							Location of De	ath		. County of Dea	th
	Funeral		Upper Ches 5. Social Security Number			Center . Age (In yrs.		Bel I		If Under 24 H	rs. 8. Date of B		arford	tholace (State or Foreign
	Director		245 46 930 Usual Residence of De	8	□M 2(X F		39 Yrs.	Months	Days	Hours Mi	s. Date of B (Month, D Feb. 28	,191	6 Nor	thplace (State or Foreign ountry) th Carolina
	show	2	10a. State 10	b. County			ty, Town or L							10d. Inside City Limits 1X Yes 2 □ No
	the M	Director	Maryland C 10e. Street and Numbe			Char	lesto	W11. 10f. Zip	Code			10a. C	itizen of What C	
	h with	Ō	409 Bayvie	Azonii										•
2	death	Funeral	11. Marital Status	w Avenue	12. Was Deced	dent Ever in U	.S. 13.		dent of Hi	spanic Origin?	(Specify Yes or Nerto Rican, etc.)	lo-	nited S1	erican Indian,
) a r	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at 2008.	þ	1 ☐ Never Married 3 🛣 Widowed 4 🗆	_	1 ☐ Yes 2 If Yes, Give Year or Da	2 💢 No		1 Yes		Specify:	ano nican, etc.)		Black, Whi	Mhite
21215-0036	in 72 ho n "natur Aedical	Completed	(Specify o	Decedent's Ed	de completed)		16a. Dece (Give	edent's Usua s kind of wo DO NOT us	al Occupa rk done o se retired	ation furing most of w	orking	16b. F	Kind of Business	/Industry
25	d within giene. er than "	mo	Elementary/Seconda	ry (0-12)	College (1-	4or 5+)		naker		•		Own	n Home	
P	be filed tal Hygid d other event,	Be C	17. Father's Name (First							18. Mother's N	ame (First, Middl			
<u> </u>	ould b Ment arkec	2	William Ha				_				yn John			
Maryland	2 sh and is m raum		19a. Informant's Name								Rural Route Num			
	1 and Health em 27 ther ti	1	Steve Carp 20a. Method of Disposi		on	20b. F	_ 409]	Bayvie	ew Av	enue, Cl	arlesto		ary land	
/15/0/altimore,	Pages nent of int. If Its int: If Its		1 XBurial 2 □C	remation 3 🔲		tate	cemetery, cre	matory`or o	ther plac	0 442	_y 20,		•	
	artme ortan injur		`4 □Donation 5 □		\sim	Clia	rlest				005 Couch Fu			,Maryland
B	permit. Departr Imports any inju		TX		X HOC	510								land 21901
	1		23a. Enter the d shock, or hear fa	lisease, or comp	lications that ca	used the deat		-	-					Approximate Interval Between
	Physician		Immediate Causa (Finadisease or condition		Ç.	TVC) Ke							Onset and Death
	/Medical Examiner		resulting in death)		a Due to (o	r as a conseq	juence of):							
	Op is	iner	Sequentially list conditi if any, leading to imme cause. Enter Underlyin	ions, diate ng	b. Due to (o	or as a conseq	uence of):							
5 %	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last		c Due to (o	r as a conseq	uence of):							
26	e be ex	calE			d		,							
27,0	tificat 19 phy as th	ledi			<u> </u>									
₹ S S S	death certificate h e attending physi id for use as the b	an/N	IF FEMALE: 23b. Was decedent pre	egnant	23c. If yes, outc	ome of pregna		□Ectopic pr	еолапсу				23d. Date of de	,
0.	0 8 9	Physician/Medi	in the past 12 mon 1 □ Yes 2 No 9 □ Unknow		4□Pregna 9□Unknov	nt at time of d wn		Other (sp					Month	Day Year
> d.	requires that the een signed by th nould be detache	by Ph	Part II. Other significan	nt conditions co	ntributing to dea	ath but not res	ulting in the	underlying c	ause give	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
Apr	w require been sig should b	ed b	<u> </u>	N							1 🗆	Yes 2	No 3□Pi	robably 4 Unknown
Ph A	> 2 2	plet	PV	\square							24a. Wa		24b. Were at	utopsy findings available
_	The lav	Completed									peri 1 Tyes	opsy ormed? 2 No	death?	completion of cause of
7/2 Vital	ysician: Th is certificate director, pag	Be (25. Was case referred examiner?	⊢						26. Place of D	eath (Check only	$-\Delta$		
55	S S	ည	1 ☐ Yes 2 No				ER/Outpatie			4 🗀 Nursing	Home 5 ☐ Res			cify)
	ding F	ion		Pending		Day Year)	28b. Time of Injury	of 2	8c. Injury Work	at ? /es 2 □ No	28d. Describe	how inju	iry occurred	
PEU	Attending r death. ector: After by the fune	ficat		investigation Could not be		of Injury - At he	ome, farm, st			162 2 140	28f. Location	(Street a	nd Number or R	ural Route Number,
줐号	al or A s after il Direction by	Certification;	4 Homicide	determined	buildin	g, etc. (Specif	(y)	noot, tactory	, 011100		City or To	own, State	е)	siai i ioste i vanber,
CA	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one)	Certifying Phy Medical Exam	vsician: To the biner: On the bas	sis of examina	owledge, dea ation and/or in	th occurred rvestigation	at the tim , in my op	e, date and pla pinion, death oc	ce, and due to the curred at the time	e cause(s	s) and manner as d place, and due	s stated. e to the cause(s)
_	To the Ho within 24 I To the Fu completely	Med	29b. Signature and title	of certifier	A C	o. stated.	la . N	290	. License	number		29d. Da	ate signed (Ment	h, Day, Year)
	F > F 0) //_	c Il	i Will		MI) N	01	0631	742	7/	117/1	7
	\		30. Name and address	of person who c	ompleted cause	o death (Item	n 23a) (Type	, Print)		1 . 40 .	1 21	4	11/	ilan Da
			JUNA 31. Date filed (Month, I	M/W	(TYG	MSK Distraria Siza	aye	1		ijjei	- Che	Say	PRUK	May Cut
	Sta Registr		JU	L 2 1 20	05	gioriai o olgina	Con Joseph	LANGE.				V		•

State of Maryland / Department of Health and Mental Hygiene

Baltimore, Maryland 21215-0036

For Stata Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** July 13 2005 7:25 p Coleman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sacred Heart Nursing Home Hyattsville Prince George's If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗗 F 579-36-3994 Yrs. Director 93 26. Dec. 1911 Richmond, Va. Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral', or Itams 23a or 28a-f show Examiner outst be natified at 1 Yes 2 No Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2250 12th Place NW 20009 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 0 1 ☐ Yes 2 X No Specify: δ Specify: ar than "natural", 3K Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Housekeeper Private 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If itam Z7 is marked oth any jury or other traumatic event size. 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Powell Lillie Sheppard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cassandra Brown / Niece 2250 12th Place NW Washington, DC 20009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State EŒBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery July 19,2005 Washington, DC 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy St. NW Washington, DC 20011 23a. Part1. Enter the disease, or compilitations hat a used the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** CARDIOPULMUNARY FAILURE /Medical Due to (or as a consequence of): **Examiner** SEVERE KYPHOSIS AND SCOLIOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner OSTEOARTHRITIS SEVERE resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-HYPERTENSION Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIABETES MELITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 24 No HYPERLIPEMIA 1 🗌 Yes 2 🗆 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To After thi 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Diractor: d in by the 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or A within 24 hours after To the Funeral Dirac completely filled in by 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. icai 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 07-18-05 D 51530 HM3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bahram Pishdad, MD 5805 Queens Chapel Rd. Hyattsville, MD 20782 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2005 Registrar

			1 - For State Registrar	State of Maryla	nd / Depa		ealth and M	1ental Hygi		0=070
						inicale of t	Jean	2. Date of Death	9.12005	25219
	Physici /Medic	al	1. Decedent's Name (First, Middle, Las David Way	yne Cr	eech	Sr.			8 ^{Day} 200 ⁹ 5 ^{ar}	2:55 am
	Examin	er	4a. Facility Name (If not institution, give Fort Washingto				Location of Death	on	4c. County of Death Prince Ge	orges
	Funeral Director		5. Social Security Number 5 7 8 - 7 4 - 1 5 4 7	ex 7. Age (In yrs	s. last birthday) 1 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 7 Month Day	9. Birthe Cour Wash	place (State or Foreign
-	p _		Usual Residence of Decedent							
	Marylar a-f show	ctor	MD 10b. County Charle	es 10c. C	City, Town or Lo	Bryans	Rd.		1	0d. Inside City Limits 1 Yes 2 No
	h with the 23a or 28 st be no	al Dire	10e. Street and Number 1490 Marshall	Hall Rd.		10f. Zip Code 206	16	10	og. Citizen of What Cour	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be notified a page.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 P No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: B	
215-0	hin 72 ho s. nn "natur Medical	pleted	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done o DO NOT use retired	during most of work	ing	16b. Kind of Business/Ind	dustry
2	i the	ОП	zionionali, roccontali, (o 12)	I	Contr	actor			Private	
Maryland 21215-0036	ild be file fental Hyg rked othe	To Be C	17. Father's Name (First, Middle, Last) David Cre	eech			18. Mother's Name	e (First, Middle, N	Maiden Sumame) Holt	
Mary	nd 2 shou alth and M 27 Is mar r treumat		19a. Informant's Name/Relationship (7 Judy Creech/ V	Type, Print) Vife	19b. Mailii 1 4 9 0	ng Address (Street a Marshal	and Number or Run	al Route Number, Rd., Br	City or Town, State, Zip	Code) MD
Baltimore,	Pages 1 a ent of Hes nt: If Item ry or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	cemetery, crei	esition (Name of matory or other plac e Park	e)		20c. Location - City or To	
Balti	permit. I Departm Importer any inju		21. Signature of Funeral Service Licen						Funeral H Wash. D (
	Dhuaisian		23a. Part1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final		ath. Do not en	er the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a conse		araisya	scuar	neart	Moense	
	ted nsit	Examiner	Secuentially list nundrions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):					
,092	te be executed ysician and te burial-transit	cal Exar	that initiated events resulting in death) Last	C. Due to (or as a conse	equence of):					
87	cate ohysi the			d						
P.O. Box 68	that the death certificate be executed today the attending physician and detached for use as the burial-transit	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
Ś	8 5 8		Part II. Other significant conditions	ontributing to death but not re	esulting in the u	nderlying cause give	en in Part I.		acco use contribute to the	ne cause of death?
0	w requir been si should	ete								
Vital Record		Completed						24a. Was an autopsy perform	prior to condeath?	psy findings available mpletion of cause of 2 No
ij	cian ertifi ector	Be	25. W s case referred to medical examiner?	11 9 1			26. Place of Deat	h (Check only one	e)	
	S S	2	1 Yes 2 No 27. Manyor of Death 1 Natural 5 Pending	Hospital: 1 Inpatient 21 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury		at	me 5 Resider	nce 6 Other (Specifi w injury occurred	γ)
Division of	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		home, farm, sti		Yes 2 No	28f. Location (Str City or Town,	reet and Number or Rura , State)	l Route Number,
	the Hospitel or nin 24 hours after the Funeral Diru npletely filled in I		29a. Certifier 1 Certifying Ph	ysician: To the best of my ki	nowledge, deat	h occurred at the tim	ne, date and place,	and due to the ca	use(s) and manner as st	lated.
	To the Hospitel within 24 hours a To the Funeral C completely filled	Medical	29b. Signature and title of certifier	niner: On the basis of examinand manner stated.	andrand/or in	vestigation, in my of			ed. Date signed (Month,	
	10		1 Andrade	V phose	200	142	005778	27 .	Tuly 20,	2005
H	12/0		30. Name and address of person who SALVAGO SYLVA	3Ter. 3001 6	tosp-7	Erint)	ne, Ch	verly	Lung law.	d
	Sta Registr		JUL 2 1 2005	32. Registrar's Sig	COLL		6	F.5		

			For State	State of	Marylar				lealth and Death	Mental				
	Physici	an	Registrar Decedent's Name (First, Middle, Last) James Burton		1,0		imou	10 01 1	<u> </u>	2. Date of Month		Z U () 5 Year	2 Tiple 2 0 3 11 0
	/Media	cal	4a. Facility Name (If not institution, give s				4h Cit	v Tours o	r Location of Dea			7 2	005	2025 ^M
	Examir	ier	Atlantic Gene	ral Hos	pital			Berl	lin			Worc	este	
	Funeral Director		3/0-40-/0/3	KM 2□F	72 Age (In yrs.	last birthday) Yrs.	Month:	er 1 Year s Days	If Under 24 Hr Hours Min	8. Date of (Month	f Birth Day, Yea 31,19	332 W	9. Birthp Çoyn ashi	lace (State or Foreign try) ngton, D.C.
-	land		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation	<u>-</u>						0d. Inside City Limits
	e Mary 3a-f sho	Director	MD Worcest	er		0cea	n Pi	nes					ł	1 ☐ Yes 2 🛣 No
	with th	Dire	10e. Street and Number					ip Code			_	itizen of W	hat Coun	try?
	leath 1	eral	6 Fantail Ct.	12. Was Deced	lent Ever in U	.S. 13.		21811		Specify Yes	US/		- Americ	an Indian,
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other then "neturel", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be neithed at	by Funeral	1 Never Married 2XX Married 3 Widowed 4 Divorced	Armed Ford	es? 2 □ No			ecify Cuba 2X☐ No	lispanic Origin? (an, Mexican, Pue Specify:	erto Rican, etc	.)	Black	white, White, Whi	etc.
5-0	72 ho netur	eted	15. Oecedent's Edu (Specify only highest grade	cation completed)		16a. Deced	lent's Us	sual Occup	ation during most of w	orking	16b.	Kind of Bu	siness/Ind	dustry
हि 2121	iene.	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)				during most of w intende		Co	onstr	ucti	on
	2 should be filed with and Mental Hygiene is marked other the aumatic event, Inc.	Be	17. Father's Name (First, Middle, Last) James Burton	Canlo	C to	'		•	18. Mother's Na			n Sumame	9)	
/ i 7 / aの 3035 Maryland	should nd Mein marke imatic	5	19a. Informant's Name/Relationship (Ty)		J.,	19h Mailir	na Addre	ss (Street	and Number or F			or Town	State Zin	Codel
<u> </u>	and 2 s saith an n 27 is ier trau		Charlene Cagle	, ,		~	-		, Ocean					0000)
ore,	00 0		20a. Method of Disposition 1 Burial 2XXCremation 3 DR	emoval from S	20b. F	Place of Dispo cemetery, crer	sition (N	ame of other plac	:8)	Date	20c. l	_ocation - (City or To	wn, State
DOD TOD Baltimor	Pag ment ant: ury o		' 4 ☐ Donation 5 ☐ Other (Specify)			e Henl				9-05		hfor		
Pi-B	permit. Departi Import any I j		21. Signature of Funeral Service License	1.7	alles				ss of Facility T					ome
	200		22a. Part1. Enter the disease, or compli shock, or heart failure. List only of	ations that ca e cause on ea	sed by dear	h. Do not ent	er the m	ode of dyin	g, such as cardi	ac or respirate	ory arrest,			Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)		ung	Cove	ev						4	Oriset and Death
	Examiner			Due to (o	ras a co sec	uence of):								
e .	p #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (o	r as a consec	uence of):								
33	cate be executed physician and the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	Due to (o	r as a consec	uence of):								
31/1933	te be e ysician e buris	dicalE												
89	ntificating physes as th	Medi	IF FEMALE:											
8 8/Box	leath certific attending p I for use as t	lan/	23b. Was decedent pregnant in the past 12 months?		ome of pregna th 2 □ Feta nt at time of c	ıl death 3□		pregnancy	,			23d. Date		ry Day Year
වරය P.O. I	the de by the dacked	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknov		leath 5L	J Other (:	specify)						
ന ഗ്	The law requires that the death certifiate has been signed by the attending tage 2 should be detached for use as	by	Part II. Other significant conditions con	tributing to dea	ath but not res	ulting in the u	nderlying	cause giv	en in Part I.					e cause of death? ably 4 Dunknown
65 767 ecord	aw rec is bee 2 shou	ompleted		AD							Mas an	24b. W	/ere autor	osy findings available inpletion of cause of
81.8		Com								1 🗆 Y	autopsy performed? es 2 /X N	d	eath?	
Vita O	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:				Oth	26. Place of Do					
27.0	Phys or this oral dii	To To	1 ☐ Yes 2 ☐No 27. Manner of Death	28a. Date of		ER/Outpatien 28b. Time of		28c. Injun	y at	Home 5 1	Residence ribe how inj			")
3 % io	inding Ph ath. iv: After th	atlor	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month	, Day Year)	Injury	М	Wor	k? Yes 2 □No					
Divis	al or Atters after de I Directo	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place o building	of Injury - At h g, etc. <i>(Speci</i> l	ome, farm, str	eet, facto	ory, office		28f. Locati City o	on (Street a r Town, Sta	nd Numbe te)	r or Rura	Route Number,
)	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	edical C	29a. Certifying Physic (Check only one)	ician: To the base and manner	sis of examina	owledge, death ation and/or in	occurre vestigation	d at the tin	ne, date and place pinion, death occ	ce, and due to curred at the t	the cause(me, date ar	s) and mar nd place, a	nner as st	ated. the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	0	A 21		2	9c. Licens	e number		29d. D	ate signed	(Month, I	Day, Year)
			Mule	and (Sle	2170		171)	5915	8		7/17	105	**
8	T 4+1		30. Name and address of person who co Richard S.					Dr. I	Berlin.	MD 218	11 (1	/ / OCUM	Tene	ns)
	< × Sta	ate	31. Date filed (Month, Day, Year)	32, Ae	gistrar's Signa	ature			1 1115	210	(_	will		/
	Regist	rar	JUL 2:0 200	13	dies o	K Do	and he	,						

State of Maryland / Department of Health and Mental Hygien 0051 - For State Ragistrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year July Kichara 8:15 AMM 16, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Md.

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, Year) Salisbury Nursing and Rehab Center
Social Security Number 6. Sex 7. Age (In yrs. last birth Wicomico 7. Age (In yrs. last birthday) **Funeral** 28-24-1282 Director Yrs. VA Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show or other treumatic event, the Medical Examenar must be notified at 1 ∰Yes 2 ☐ No Directo JOF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō items 23e 1 and 2 should be filed within 72 hours after death : 1eatth and Mental Hygiene. 9m 27 is marked other then "natural; or items 23 Funerai 12. Was Dicedent Ever in U.S.
Armed Forces?

1 Mayes 2 No 1949

If Yes, Give
Year or Dates: 1951 Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Ď Specify: Blac 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Efementary/Secondary (0-12) College (1-4or 5+) 2+4 borer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be anes 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: if Item 27 is any njury or other treu once. Pocome Ko Burw 101 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Hone Po * 4 ☐ Donation 5 ☐ Other (Specify) Portist 21. Signal of Funeral Service Licensee Address of Facility Benefic 0.0. BOX331 Po comoka 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician car /Medical Due to (or as a con equence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated excellent.) Due to (or as a consequence of) Examine The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Dav 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by should be 1 res 2 □ No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 1 Tyes 2 🗆 No 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Pface of Death (Check only one) Hospital: Other: 4 Warsing Home 5 Residence 6 Other (Specify) 2[7]No 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation death. M 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 / Homicide within 24 hours after To the Funerel Direct 1 Detritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number to car 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) WILLIAM ROBINS, M.D. 200 CIVIC AVE., SALISBURY, MD. 21804 31. Date filed (Month, Day, Year) JUL 2 0 State 2005 Registra

RICHARD CHURCH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 7 Year **Physician** Jennifer Cresko 18 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Atlantic General Hospital Berlin Worcester If Under 1 Year II Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country)
 PA 5. Social Security Number . Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F Yrs. Director 23 188-62-3652 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Northampton **Bethlehem** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2633 Jacksonville Rd. 18017 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Student None and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Richard Cresko Linda Levandoski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Importent: If item 27 Is any injury or other treu Richard Cresko/Father 2633 Jacksonville Rd., Bethlehem, PA 18017 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ^ 4 □ Donation 5 □ Other (Specify) Holy Savior Cemetery 7/22/2005 Bethlehem. PA

22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licenses 108 William St., Berlin, MD 21811 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Opseyand Death Immediate Cause (Final disease or condition resulting in death) splenic artery oneurysm **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Sinpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date ol Injury (Month, Day Year) 27. Manney of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pendina investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 22a) (Type, Print)

State Registrar

W

でいる万

DE MYCHABI DENEY

13erlin

29 Broad St. Juite 201

31. Date filed (Month, Day, Year)

			For State Registrar	State of M	-	artment of H		nd Mental Hy	giene	5 25283
H	Physici	an	1. Decedent's Name (First, Middle, Last	_				2. Date of De	ath Day Y	3. Time of Death
	/Media	cal	Patricia Ann (4a. Facility Name (If not institution, give			4b. City, Town, or	Location of	July	14, 2(005 3:00a ^M
	Examir	ner	Anne Arundel M				napol			ne Arundel
	Funeral		Social Security Number 6. Se		ge (In yrs. last birthday,	If Under 1 Year Months Days	If Under 2		h 9.	Birthplace (State or Foreign Country)
	Director		213-34-0046 Usual Residence of Decedent] M 2[3 ∕F	68 Yrs.	Monard Days	110010	Oct. 3	0, 1936	MD
	/land		10a. State 10b. County		10c. City, Town or L					10d. Inside City Limits
	e Mar	ctor	MD Anne Ar	rundel		Severn	a Par	k ———		1 ☐ Yes 23X No
	with th	Director	10e. Street and Number			10f. Zip Code	16		10g. Citizen of Wha	
	ns 23	Funeral	269 Tolstoy Lane	12. Was Decedent	Ever in U.S. 13.	211 Was Decedent of Hi		in? (Specify Yes or No		SA American Indian,
36	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show afterl Examinat must be notified at	by Fun	1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces' 1 Yes 2 X If Yes, Give Year or Dates:	? No	If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		jin? (Specify Yes or No , Puerto Rican, etc.)	Black, Specify:	White, etc. White
21215-0036	72 hou	ted	15. Decedent's Edi (Specify only highest grad		16a. Dece	dent's Usual Occupa	ation	of working	16b. Kind of Busin	ess/Industry
121	within lene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+) life.	kind of work done of DO NOT use retired		GI WOIKING	77.	
d 2	filled Hygi ther ant, I		12 17. Father's Name (First, Middle, Last)			Homemak		r's Name (First, Middle,		ome
/lan	0 0 0 0	To Be	James E. Bromwell				Mary	Willis		
Maryland			19a. Informant's Name/Relationship (T	ype, Print)				r or Rural Route Numbe		
	1 an Heali em 2 ther		Donald F. Coolaha 20a. Method of Disposition	n/Husban	20b. Place of Disp	osition (Name of		Severna Pa	ark, MD 2'	
Baltimore,	of of		1 ☐ Burial 2 □ Cremation 3 □			matory or other place 11 Cemete		Jul. 18, 2005	Brooklyn	
Balt	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Lice	aslon		arranco & 195 Gov. R	* Sons	_	erna Park erna Park	Funeral Home MD 21146
			214. Part1. Enter the disease, or comp shock or heart failure. List only of	lications that cause ne cause on each I	d the death. Do not en	-				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Rey	Suntan	Fach	w			Onset and Death
	/Medical Examiner		(Salaring III Goddin)	Due to (of as	s a consequence off.	To To	-7			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence of):	quin	A			
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. /2	each (a s a consequence of):	nees				
8760,	ate be executed hysician and the burial-transit			Due to (or as	a consaquence on.					
687	ate hy:	ledic		g						
Вох	death certific e attending p ed for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth		Ectopic pregnancy			23d. Date o	
0	0 00	Physician/Medical	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant a 9☐ Unknown	t time of death 5[Other (specify)			Month	Day Year
ار	tha de	by Ph	Part II. Other significant conditions co	ntributing to death t	out not resulting in the u	inderlying cause give	n in Part I.	23e. Did to	bacco use contribu	te to the cause of death?
rds,	w requires been signi should be	leted b						1 🗆 1	'es 2 ₹No 3[Probably 4 Unknown
	as b	plet						24a. Was	sv prio	e autopsy findings available r to completion of cause of
_	(Q LL	Compl						perfo		th? Yes 2□ No
Vital	Physicien: This certificatal director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 ☐ ER/Outpatie	nt 3□ DOA Othe		of Death (Check only o		0.74
		\vdash	27. Manner of Death	28a. Date of Inju	ury 28b. Time o	" 3LI DOA	at	sing Home 5 Resid	ow injury occurred	Specify)
sior	Attending F r death. Bctor: After by the funer	atlo	1—Natural 5 Pending investigation	(World), De	iy reary injury		res 2□N	lo		
<u>-</u>	of or Attsno after death Director:	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	jury - At home, farm, st tc. (Specify)	reet, factory, office		28f. Location (5 City or Ton	Street and Number on, State)	or Rural Route Number,
	oric ore ille	edical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	sician: To the best iner: On the basis of and manner st	of examination and/or in	h occurred at the tim vestigation, in my op	e, date and inion, death	f place, and due to the of hoccurred at the time, of	cause(s) and manne date and place, and	er as stated. due to the cause(s)
	To the Hosi within 24 ho To the Func completely f	Me	29b. Signature and title of certifier			29c. License		1	29d. Date signed (A	Aonth, Day, Year)
)			Center At	ani	,000	13	33	06	7/14	105
			30. Name and address of person who c	ompleted cause of	Sath (Item 23a) (Type,	Print)	6 20	Ob Annapo	Le In A	2860
	Sta		31. Date filed (Month, Day, Year)		rar's Signature	1-0 11	76'	v vinity po	ענים עינים	4174
	Registi	rar	JUL 15 2	UUD COU	en to	Sports				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1 tem 29d per doc 848 10-17-05 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month anie Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death)1 (5 baster) (C DUY if Under 24 Hrs. If Under 1 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 1 □ M 2 K F Days Min. 81 Yrs. 218-16-7646 MARÝLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No MARYLAND WICOMICO WILLARDS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7574 NEW HOPE ROAD 21874 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BOOKKEEPER POULTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **JOHN** WILKINS FLORA Μ. TUBBS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7369 MARKET ST., WILLARDS, MD 21874 LARRY E. DUNHAM/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State NEW HOPE CEMETERY 7/21/05 ^¹ 4 □ Donation 5 □ Other (Specify) WILLARDS, MARYLAND 21. Signature of Funeral Service, Licensee 22. Name and Address of Facility HASTINCS FUNERAL HOME, SELEYVILLE, DE. 19975 Approximate Interval Between Onset and Death Part1. Inter the disease, or complications the class the shock, or heart failure. List only one caus on each line. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) GROWL Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 24a. Was an autopsy 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) No. Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 1 Tyes Dunpatient 3∏ DOA 28a. Pate of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ✓ □ Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b Signature and title of cer

Examiner The law requires that the death certificate be executed o. 29dd Records, F or Attending Physician:

Physician

/Medical

Examiner

Director

Completed by Funeral

Be

Examiner

Completed by Physician/Medical

Certification: To Be

Medicai

Funeral

Director

Item 27 ia marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at

al Hygiene.

. Pages 1 and 2 should be fil iment of Health and Mental H tant: If Item 27 ia marked otl

ō

permit. Page Department of Important: If any injury or once.

Physician

/Medical

nding physician and use as the burial-transit

signed by the at d be detached fo

page 2

director,

After

after death.

within 24 hours a To the Funeral I

completely filled in by the funeral

the Maryland

filed within 72 hours after death with

Baltimore, Maryland 21215-0036

State Registrar

COASTAL HOSPILE D 2. Registrar's Signature Modern & Aparlle

30. Name and address of person who completed cause of path (Item 23a) (Type, Print)

DAM CSUAL NO 31. Date filed (Month, Day, Year) JUL 2 0 2005

D26278

Pubix 1733 Salus

	1-	For State Registrar	State of Marylan	d / Depa		h and Me	ental Hygie	_	
Physicia		Decedent's Name (First, Middle, Last		•	D 1		2. Date of Death Month	Day Year	
/Medica	I	Margueitte		ouise	Dutrow		JULY	29 2009 4c. County of De	1100
Examine		Facility Name (If not institution, give Vestern Maryland		. ~	4b. City, Town, or Locati	ion of Death	· ·	Vashingto	
Farmanal		Social Security Number 6. Se				der 24 Hrs.			irthplace (State or Foreign Country)
Funeral Director			™ % F 76	Yrs.	Months Days Hou	irs Min.	8. Date of Birth (Month, Day, Y March 6	, 1929 M	daryland
Activities at the maryland		a. State 10b. County Iaryland Frede:		y, Town or Lo	Frederic	k			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
TRE	10.	e. Street and Number 313 Willow Avenue			10f. Zip Code	217		g. Citizen of What C	Country? U.S.A.
TASE ANTREW 1215-0036 within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show ha Madical Examitine in water and the matified at	Dy runeral Director	Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in U. Amed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	í	Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 ☐ Yes 2 ☑ No Spec		eify Yes or No- lican, etc.)	14. Race - Arr Black, Wh	
215-0036 lithin 72 hours afi	ered	3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grad		16a. Dece (Give	dent's Usual Occupation kind of work done during i DO NOT use retired)	most of workin	g 16	6b. Kind of Busines	
/ N pat		Elementary/Secondary (0-12)	College (1-4or 5+)		ephone opera			elephone	Company
re, Maryland 2 re, Maryland 2 s 1 and 2 should be filed theath and Mental Hygi itam 27 is merked other other traumatic event, il	ย 17 ยา 17	. Father's Name (First, Middle, Last)			18. M	lother's Name	(First, Middle, Ma	aiden Sumame)	
yla yla ould the Ment Ment Ment Ment Ment Ment Ment Men	<u> </u>	Milton Harris					le Smith		<u> </u>
Mar Aar 2 sho 2 sho 1 s m 1 s m raum		a. Informant's Name/Relationship (T)			ng Address (Street and Nu				
E, N 1 and Health Health thar tı		obert T. Dutrow,	20h P	lace of Diene	Willow Avenu	Da Da		Mary Land Oc. Location - City o	
		fX□ Burial 2 □ Cremation 3 □ I	Removal from State M+ C	emetery, cre	matoni or other place)	1	1, 2005		rick, Maryla
MRENCE Baltimore permit. Pages 1: Department of He Important: If itan any injury or oth	4.00	*4 Donation 5 Dother (Specify,			2. Name and Address of F	acility asford	Funeral	Home	
A	Im	Ga. Part1. Enter the disease, or comp shock, or heart failure. List only o			106 Fast Ch ter the mode of dying, such	nurch S n as cardiac or PISO	treet, respiratory arres	Frederic	k Mary Land Approxi ate Interval Between Onset and Death
/Medical Examiner	re	sease or condition sulting in death)	Due to (or as a consequ	uence of):	20	*)			Vien o C
	if if	equentially its conditions, any, leading to immediate	b. Due to (or as a consequ	uence of):	BRILIATI	ON		•	1CHT-S
60, C	Examiner and the	leguentially its conditions, any, leading to immediate use. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last	c. END STA	AGIE	KIBNE	X .97.S	EASE	•	Y CARS
76(te be ysicia	100		d. DIABET	GG (S	KIDNE, MEZLIT	US	•		YEARS.
Division of Vital Records, P.O. Box 68 Hospital or Attanding Physician: The law requires that the death certificat 44 hours after death. Funaral Diractor: After this certificate has been signed by the attending phytely filled in by the funeral director, page 2 should be detached for use as the		FEMALE: 8b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	i death 3[□Ectopic pregnancy □ Other (specify)			23d. Date of d Month	elivery Day Year
rds, P quires that n signed b		nt II. Other significant conditions co	ntributing to death but not rest NOMEGAZ MA	ulting in the u	nderlying cause given in P	art I.	1		to the cause of death? Probably 4 Profixenown
ecord law requir as been si 2 should l	Completed	ANG	mia.				24a. Was an autopsy	24b. Were a	autopsy findings available completion of cause of
The I	E						performe	ed? death?	_
Vital Jician: J		. Was case referred to medical examiner?				lace of Death	(Check only one))	
of V Physic this ce	0	1 ☐ Yes 2 1 No	Hospital: 1 X Inpatient 2 □					ce 6 □Other (Sp	ecify)
on of Vita ding Physician: h. After this certific funeral director.	27	Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work?	21/2/No	Bd. Describe how	vinjury occurred	
Division of Vital Records, for Attanding Physician: The law requires that redeath. Director: After this certificate has been signe in by the funeral director, page 2 should be or	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, st	2000	X 21	8f. Location (Stre City or Town,		Rural Route Number,
Divisio To the Hospital or Attandi within 24 hours after death. To tha Funaral Director: A completely filled in by the t			rsician: To the best of my kno iner: On the basis of examina and manner stated.						
No the Somple Somple		b. Signature and title of certifier			29c. License numb	ber	1	d. Date signed (Mor	• • • • • • • • • • • • • • • • • • • •
		No or	3º M.D) 7	5450	331.		Lilly.29	2005
	30	. Name and address of person who c		n 23a) (Type,	Print) 1500 Pen	nsy1var	nia Aven	ue	340
8	2		170 316		Hagersto	wn, MD	21742		
Stat Registra	~	AUG 0 3 201	32 Aegistrar's Signa	ture	ale				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Deremer 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 718 Brookfield Avenue Cumberland Allegany If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Dec 28, Birthplace (State or Foreign Country) 1 ☐ M 2 🔀 F Yrs. 214-05-9888 MD 88 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Allegany Cumberland 1√ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 718 Brookfield Avenue 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white 1 Yes 2 No 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor MD State 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Insogna Francina (Cenelli) Insogna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Monahan 1209 Holland Street daughter Cumberland MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Cemetery 8/2/2005 4 □ Donation 5 □ Other (Specify) Cumberland MD 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland MD 21502 23a. Fant Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, effect, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DEHYDRAT ION. disease or condition resulting in death) Due to (or as a consequence of): SEVERE IMMOBILITY Sequentially list conditions, if any leading immediate cause. Enter Underlying Cause (Disease or injury OSTEO POROS IS that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9☐ Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 ☐Unknown OSTEUPORUSIS 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No NA 2 No Yes 26. Place of Death Check onl one Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work?

Examiner Examiner The law requires that the death certificate be executed burial-transit and Box 68760. the attending physician ned for use as the buria Physiclan/Medical P.O. I signed by to Records, þ Completed certificate Division of Vital To the Hospitel or Attending Physicien: Be 2 this After within 24 hours after death.

To the Funerel Director: A
completely filled in by the fu

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

or 28e-f show recimust be notified at

Items 23a

permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or Item any injury or other treumatic event. The Medical Experience ODEs.

Physician

/Medical

Baltimore, Maryland 21215-0036

Director

Funeral

ģ

Completed

IF FEMALE Certification:

Medical

HYPERLIPT DEM IA MENOPAUSE

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 Natural 5 Pending 2 Accident 3 ☐ Suicide 4 Homicide

29a. Certifier

investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day Year) NIA-

28b. Time of

NIA

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) NIA

28d. Describe how injury occurred NIA.

28f. Location (Street and Number or Rural Route Number, City or Town, State) NIA

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of

29c. License number D0059121. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T. MAL IK 31. Date filed (Macin Gay, Year) 2005

ରେ ଚ KENT Registrar's Signature

AVE, SUTTE 204

CUMBERIAND, MD 2150

State Registrar

3

Phy /N Ex

Fun Dire

	For State Registrar	State of Ivial	yland / De <i>C</i>	partmei <i>ertifica</i>			ind M	ental H	lygier Reg. r		00	0 = 1	
	1. Decedent's Name (First, Middle, Last)							2. Date of	Death	20	U 3	G. Time	& Death
ı	MARK EUGENE DOUDN	Δ SR						Month July		Day 2005	Year	1:20	а
ľ	4a. Facility Name (If not institution, give s			4b. City	, Town, or	Location o	f Death				y of Deat		
ı	4702 Guilford Roa	d		Co1	lege	Park]	Princ	ce Ge	orge's	
	5. Social Security Number 6. Sex 1払	7. Age	(In yrs. last birthda	Months	or 1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of (Month, March	Birth Day, Yea	920	9. Birti Co Ind	hplace (State puntry) iana	or Fore
	Usual Residence of Decedent												
	10a. State 10b. County		10c. City, Town or	Location								10d. Inside (ity Limi
	Maryland Prince Ge	orge's	College	Park								1 X Yes	2 🗆 N
ſ	10e. Street and Number			10f. Z	ip Code				10g. (Citizen of	What Co	untry?	
l	4702 Guilford Roa	d		20	740				U.	S.A.	•		
Ī	11. Marital Status	Was Decedent Ev Armed Forces?	rer in U.S. 1	3. Was Dece If Yes, spe	edent of His	spanic Orig	gin? (Spe	ecify Yes or	No-			nican Indian,	
	1 Never Married 2 Married	1 X Yes 2 No		1 ☐ Yes		Specify:	, 1 0010	riodii, etc./			ack, White		
	3 X Widowed 4 ☐ Divorced	If Yes, Give 19 Year or Dates:	949-59	1 103	201140	зреспу.				Speci	ny: W	hite	
Ī	15. Decedent's Educ (Specify only highest grade		16a. De	cedent's Usi	ual Decupa	tion	of worki	na	16b.	Kind of E	Business/	Industry	
-	Elementary/Secondary (0-12)	College (1-4or 5+)	life	B. DO NOT	use retired)	army most	o, work,	.9	Uni	ivers	sity		
L		7+	Pro	fessor					of	Mary	1and	l	
	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Midd	de, Maid	en Suma	me)		
	Eugene Doudna					Luc	ille	Wyant	:				
	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Ma	ailing Addres	is (Street a	nd Numbe	r or Rura	l Route Nur	nber, City	y or Town	, State, Z	Zip Code)	
	Tammie Stanton - D	aughter	470	2 Guil	ford	Road	, Co	llege	Park	c, Ma	ry1a	nd 207	40
-	20a. Method of Disposition	-	20b. Place of Dis	sposition (Na	me of	2)		ate	20c.	Location	- City or	Town, State	
	1 ☐ Burial 2 M Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Metropoli				7/19	/2005	Δ1	lexar	dria	, Virg	inis
ŀ	21. Signature of Funeral Service License	0	Tiberoposis			- ,						, P.A.	
	VI & Galace											20781	
	23a. I Art. Enter the disease, or com- nock, or heart failure. List only on lmm, late Cause (Final disease or condition resilting in death)	Cancer o		ngue								Interval Be Onset and	
ı	Sequentially list conditions, if any, leading to immediate	Due to (or as a	conceduance of:										
	cause. Enter underlying Cause. Chesculor in the cause of	Due to (or as a	consequence of):										
	cause. Enter Underlying Cause Unsease or injury that initiated events	Due to (or as a											
	cause. Christone or highly that initiated events resulting in death) Last	Due to (or as a	consequence of): pregnancy Fetal death	3 ⊟Ectopic p 5					-		ate of deli	ivery Day	Year
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	Due to (or as a sc. If yes, outcome of 1 Live birth 2 4 Pregnant at times 1 Unknown	consequence of): pregnancy Fetal death me of death	3 □Ectopic p 5 □ Other (s	pecify)	n in Part I.			d tobacc	o use con	lonth ntribute to	,	death?
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a sc. If yes, outcome of 1 Live birth 2 4 Pregnant at times 1 Unknown	consequence of): pregnancy Fetal death me of death	3 □Ectopic p 5 □ Other (s	pecify)	n in Part I.		1 (24a. W	Yes as an topsy	o use con	onth atribute to a Pro Were au prior to c	Day the cause of	death? Unknow
	cause. Enter Underlying that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions con	Due to (or as a sc. If yes, outcome of 1 Live birth 2 4 Pregnant at times 1 Unknown	consequence of): pregnancy Fetal death me of death	3 □Ectopic p 5 □ Other (s	pecify)			24a. W au pe 1 U Yes	Yes as an atopsy aformed?	o use con	ntribute to	Day the cause of obably 4 X ttopsy findings completion of	death? Unknow
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions con	Due to (or as a	pregnancy Fetal death me of death not resulting in the	3 □Ectopic p 5 □ Other (s e underlying	cause give	26. Place		24a. W au pe 1 Yes	Yes as an atopsy aformed?	o use con	onth atribute to 3 Pro Were au prior to codeath?	Day the cause of obably 4 X topsy findings completion of	death? Unknow
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 25. Was case referred to medical examiner? 1 Yes 2 No H.	Due to (or as a a a a a a a a a a a a a a a a a a	pregnancy Fetal death me of death not resulting in the	3 DEctopic p 5 Other (s e underlying	cause give	26. Place □ 4 □ Nur	rsing Ho	24a. W au pe 1 Yes	Yes as an topsy formed? 2 X !	M use cor 2 No 24b.	were au prior to c death?	bay the cause of obably 4 \(\sum_{\text{topsy}} \) findings completion of 2 \(\sum_{\text{No}} \) No	death? Unknow
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions con	Due to (or as a	pregnancy Fetal death me of death not resulting in the	3 Ectopic p 5 Other (s e underlying tient 3 D e of	cause give	26. Place r. 4□ Nur at	rsing Ho	24a. W au pe 1 Yes	Yes as an topsy formed? 2 X !	M use cor 2 No 24b.	were au prior to c death?	bay the cause of obably 4 \(\sum_{\text{topsy}} \) findings completion of 2 \(\sum_{\text{No}} \) No	death? Unknow
	cause. Enter Underlying that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions condition	Due to (or as a Bc. If yes, outcome of 1 Live birth 2 4 Pregnant at tie 9 Unknown tributing to death but	pregnancy Fetal death me of death not resulting in the 2 ER/Outpat Year) 28b. Time Injur	3 Dectopic p 5 Other (s e underlying tient 3 December 9	cause give	26. Place □ 4 □ Nur	rsing Ho	24a. W au pe 1 Pe 26 Check on 6 Check on 28d. Describ	Yes as an topsy offermed? s 2 X to y one) esidence be how in	o use cor 2 No 24b.	onth 3 Pro Were au prior to c death? 1 Yes	bay the cause of obably 4 \(\sum_{\text{topsy}} \) findings completion of 2 \(\sum_{\text{No}} \) No	death? Unknow availab availab
	Cause. Enter Underlying Cause. Character of highly that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a Bc. If yes, outcome of 1 Live birth 2 4 Pregnant at times 9 Unknown tributing to death but 28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc.	pregnancy Fetal death me of death not resulting in the 2 □ ER/Outpat Year) 28b. Time Injur Y- At home, farm, (Specify)	3 DEctopic p 5 Other (s e underlying tient 3 Decorporate of y M street, factor	cause give OA Dthe 28c. Injury Work 1 Yry, office	26. Place F. 4 Nur at ? es 2 N	No	24a. Wall part of the control of the	Yes as an topsy informed? s 2 X 1 y one) esidence how in (Street Town, State cause	M o use cor 2 No 24b. 7 No 6 Ott jury occu and Num ate)	onth artribute to 3	Day the cause of obably 4 \(\frac{N}{2} \) topsy findings completion of 2 \(\frac{N}{2} \) No cify)	death? Unknow available ause of
	Cause. Enter Underlying Cause. (Check only) IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a Bc. If yes, outcome of 1 Live birth 2 4 Pregnant at tie 9 Unknown tributing to death but 28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc.	pregnancy Fetal death me of death not resulting in the 2 □ ER/Outpat Year) 28b. Time Injur Y- At home, farm, (Specify)	3 Ectopic p 5 Other (s e underlying tient 3 De e of y M street, factor eath occurred	cause give OA Dthe 28c. Injury Work 1 Yry, office	26. Place IF. 4 Nur at ? Yes 2 N	No	24a. Wall part of the control of the	PYes Bus an itopsy informed? So 2 X 1 in y one) Sesidence we how in a (Street Town, State as e., da	Mo use cor 2 No 24b.	were au prior to c death? 1 Yes ther (Specified and a specified ay the cause of obably 4 \(\frac{N}{2} \) topsy findings completion of 2 \(\frac{N}{2} \) No cify)	death? Unknow available ause of	

DHMH 17 Rev 1/2001

State Registrar Martin D. Weltz, MD
31. Date filed (Month, Day, Year)
JUL 2 0 2005

7525 Greenway Center Drive, #205, Greenbelt, MD 20770
32. Egistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Virginia Blackistone 23, July 2005 10:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 22565 Calvert Street St. Mary's Leonardtown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 K F Director Yrs. 577-20-0483 85 20, 1919 Maryland Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ref', or items 23e or 28a-f show Examiner must be notified at 1 TYes 2 No Director St. Mary's Maryland Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 22565 Calvert Street U.S.A. Completed by Funeral 20650 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Yes 2XXNo If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: 3 Widowed 4 Divorced "naturef", White treumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other then Elementary/Secondary (0-12) College (1-4or 5+) Owner / Operator Restaurant /Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Mental I Reginald Golden Blackistone Ella Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an Benedict D. Duke, Jr., Son P.O. Box 1157 Leonardtown, Maryland 20650 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages nent of I permit. Pages Department of Importent: if it any injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Our Lady's Cemetery | 7-28-2005 ^¹ 4 □ Donation 5 □ Other (Specify) Leonardtown, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee P.O. Box 279 Leonardtown, Maryland 20650-0279 elos K 1100052 1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** congestive disease or condition resulting in death) months /Medical Due to (or a consequence of): Examiner (GP8 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The taw requires that the death certificate be executed use as the burial-transit ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacço use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ■ Yes autopsy performed? certificate 1 Yes 2 X No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 🗌 Yes Other: 4 Nursing Home 5X Residence 6 Other (Specify) Certification: To 2 **X** No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending 1 Natural investigation 1 Yes 2 No 2 Accident Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) uta \$003265 105 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAURRI 22335 EXPLORATION 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2005 Registrar

		4 State	State of Marylan		rtment of F		·				
Physici	an.	1. Decedent's Name (First, Middle, Last)	H//21/05,BMW,McC	D Cel	incate or t	Dealli	2. Date of De	ath Day	. U U 5 Year	3. Time of Death	}
/Medic	al	Jon Coleman Dilweg		oleman			July 1	7, 2	005	9:15pm	M
Examin	er	4a. Facility Name (If not institution, give st			_	r Location of Death			County of Death		
Funeral		13321 Manor Stone 3 5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	Germant	If Under 24 Hrs.	8. Date of Bir	th	ntgomery 9. Birth	place (State or Forei	gn
Director		238-42-1858	^{M 2□ F} 76	Yrs.	Months Days	Hours Min.	June 27	, 192	29 Wisc	onsin	
and and		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	cation					Od. Inside City Limit	ts
Maryl	tor	Idaho Bannock	Po	catello	2					1 ☐ Yes 2 🛣 N	ю
th the	Director	10e. Street and Number		Carolin	10f. Zip Code			10g. Citiz	zen of What Cou	ntry?	
ath wi	ral	4180 Johnny Creek R			83204				ed Stat		_
items items	Funeral	11. Marital Status 1 Never Married 2 Married	 Was Decedent Ever in U. Armed Forces? 1	.S. 13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 1	4. Race - Americ Black, White,		
urs af	by	3 Widowed 4 Divorced	If Yes, Give 1954 Year or Dates: 1975	<u>1</u> 1	☐ Yes 2X No	Specify:			Specity: Whi	te	
72 ho natur	Completed	15. Decedent's Education (Specify only highest grade	ation	16a. Deced	ent's Usual Occup	durina most of work	ina	16b. Kir	nd of Business/In	dustry	
within	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retired	d)		T7 J.,			
Hygie Hygie other		17. Father's Name (First, Middle, Last)	5+	Teach	er	18. Mother's Name	e (First, Middle,		cation Sumame)		
lid be fental rked c	To Be	Lavern Dilweg				Eleanor	Colema	n			
and N		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	g Address (Street	and Number or Run	al Route Numbe	er, City or	Town, State, Zip	Code)	_
and and lealth m 27		Nancy JoAn Dilweg	(Wife)		Armeter - No. of the Contract of	reek Road	-				_
T in the state of	-	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re	moval mom State		sition (Name of anatory or other place	(e)	Date HR			own, State tiki	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mental Hygiene. Mimportant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Exactinat must be notified at once.		*4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		22	Cenetery Name and Address	ss of Facility De	Vol Fun		tello, I	LD	_
Dep den den den den den		The toll Que		1.0	_East_Dec	er Park D rg, MD 20	rive				
		23a. Part1. Inter the limitse, or complice hook, or heart failure. List only on	alions that caused the death					rest,		Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition	Coronary	ar-	tery	disease	}			Onset and Death	
/Medical Examiner		resulting in death)	Due to (or as a consequence	uence of):							
	er	Sequentially list conditions, b.	Due to for as a consequence	uerice of).		-	_				_
d d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
be executed sicien and burial-transit		resulting in death) Last	Due to (or as a consequent	uence of):							
# × 6	Physician/Medical	d.									
eath certifica attending ph I for use as th	/Me	IF FEMALE: 23	ic. If yes, outcome of pregna	ancy				2	3d. Date of delive	201	
death e atter d for u	lciar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Feta 4 Pregnant at time of de	Ideath 3	Ectopic pregnancy Other (specify)	1			Month	Day Year	
at the de by the stached	hys	9 Unknown	9L Unknown								
res tha signed I be det	þ	Part II. Other significant conditions cont	ributing to death but not resi	ulting in the un	derlying cause give	en in Part I.			/	ne cause of death?	
w require been si should t	Completed						101		(No 3 ☐ Prob	ably 4 Unknow	л
has t	mpl					· · · · · · · · · · · · · · · · · · ·	24a. Was autop perfo			psy findings available mpletion of cause of	
	e Co	25. Was case referred to medical				26. Place of Deatl	1 Tes	2 X No	1 ☐ Yes	21X/No	
Physician: this certific al director,	To B	examiner?	ospital:	ER/Outpatient	3 DOA Oth				XOther (Specific	Niece's Residence	ρ.
if or Attending Physician: after death. Director: After this certifica in by the funeral director.		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun World		28d. Describe l			Residence	
r Attendi er death. rector: A by the fu	cath	2 Accident investigation 3 Suicide 6 Could not be			Yes 2 □ No	201				_	
l or Al after o Direc	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	et, factory, office		City or Tox	vn, State)	l Number or Rura	i Houte Number,	
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the f		29a. Certifier 1 ☐ Certifying Physi	cian: To the best of my kno	wledge, death	occurred at the tin	ne, date and place,	and due to the	cause(s)	and manner as si	ated.	
To the H within 24 To the Fa completel	ledical	(Check only one) 2 Medicel Exemine	er: On the basis of examina and manner stated.	ition and/or inv							
To To	Σ	29b. Signature and title of certifier	- les Ma	en M	29c. License	e number 5 / 9 / 0		29d. Date	signed (Month,	Day, Year)	
5+1		30-Namo and address of	melleted earner of the th	2201 17	V VC	11110		UU/	4 10, 2		
		30. Name and address of person who com	May MD, I	11110 K	Packaull.	e Pike,	G-100.	Ro	ckvill	e MD 2085	7
Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	R.P			100	-1 1776	/	
Registr	ar	JUL 2 0 2005	Harres S.	Baller							

DHMH 17 Hev 1/2001

Baitimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- Statement ITEM #5 PER FH G846 8/19/09rtificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2005 July 18, 11:10 a M 4a. Facility vame (It not institution, give street and number) /Medical 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Manor Care-Silver Spring Silver Spring 8. Date of Birth (Month, Day, Year) June 18, 1 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 3149 213-38-6149 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 K F Director 85 Yrs 1920 Germany Usual Residence of Decedent Manyland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or Items 23a or 28a-f show Evantirer must be notified at Silver Spring Director Maryland Montgomery 1 ☐ Yes 2 No death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20901 USA 306 Waterford Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2€ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Iter 1 Never Married 3 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced The Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Department of Health and Mental Hygie Important: If item 27 is marked other tany Injury or other traumatic event, Italy once. 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elizabetha Blatt Ludwig Heil 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 Waterford Road, Silver Spring, MD 20901-3425 Kurt W. Dubin/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State July 23 Burtonsville Union Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 2005 Burtonsville, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sebsis Physician disease or condition resulting in death) Deek /Medical Due to (or as a consequence of) Examiner ancex with me tastasis Vax Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner inding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 No 2 No 1 Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 ☐ Yes 25 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending after death. Director: Af investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation in my spiritual death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2770 AT 20MI)

Registrar

State

2 0 2005 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

22. Registrar's Signature

(awn)

202

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Day **Physician** Jean Depen 0416 M July 3 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis
Under 1 Year | If Under 24 Hrs. If Under 1 Year Days Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 → F Months Hours Director 219-16-0425 79 Jan. 24, 1926 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at tx∃xYes 2 No Maryland Directo Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 149 Williams Drive Completed by Funeral death 21401 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Menial Hygiene. ant: If Item 27 is marked other than "natural", or Item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: 3 Widowed 4 □ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ္ရ Douglas Howard Winifred Lee Stevens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Schwallenberg/ daughter 1601 Bishop Rd. Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
sny injury or ot 1 □ Burial 2 □ Cremation 3 □ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) St. Mary's Cemetery 7-21-05 Annapolis, MD 22. Name and Address of Facility John M. Taylor Funeral Home, 21. Signature of Funeral Service Lice 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** E. brosis 7-3 Dulmunic Due to (or as a consequence of resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consumence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, physician Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Į in the past 12 months? Year Month Day 4□Pregnant at time of death 5 Other (specify) detached P.O. the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed? 1 Yes 2 1 No the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 F-H0 1 Impatient 2 ER/Outpatient Certification: To 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation after death. 2 No 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) yd ni 4 Homicide pellil To the Hospital • Funeral 1 cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and 05/8/9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 132 Huliday of s-ite 241 Annapulis MD Mitthe J. Wilte 31. Date filed (Month, Day, Year) 32. Sgistrar's Signature State Registrar

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day 2005 Year **Physician** JULY 15, MARIETTA POOL DORSEY 2:52 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner WESTMINSTER

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (Country) |

MAY 24, 1922 CARROLL CO., MD SUMMERVILLE AT WESTMINSTER 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🖾 F Director 213-18-8470 83 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in and Mental Hygiene. 7 Is marked othar than "natural", or Itams 23e or 28a-1 shov treumatic avent, the Modical Examiner rust be nutified at 28a-f show 1 ☐ Yes 2 ☐ No Director MD CARROLL WESTMINSTER 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21158 U.S.A. 1910 PATRICIA COURT Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ☐Yes 2∏No Yes, Give 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 🌠 No Specify: ğ Specify: WHITE 3 Widowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 72 College (1-4or 5+) SUPERMARKET 12 DELI MANAGER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be REUBEN BRICE POOL MARY DUVALL ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health at: If itam 27 Is 1910 PATRICIA CT. WESTMINSTER, MD 21158 HELEN LEE - DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State parmit. Page Department of Importent: If any injury or CARROLL CREMATION JULY 15, 2005 HAMPSTEAD, MD *4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
MYERS-DURBORAW FUNERAL HOME, M01191 ST. WESTMINSTER, MD WILLIS 21157 23a. Palt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 341 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner burial-tran Due to (or as a consequence of): attending physician for use as the buria Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 No Month 4☐Pregnant at time of death 5 Other (specify) ed by the detached Records, P.O. 9☐ Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No Vital 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check vin).

Dthen: 4 Nursing Home 5 Residence 6 Rother (Specify) Asst.

Secretic how injury occurred Living examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 funeral dir of Manher of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: Division 1 Natural 2 Accident 5 Pending Injury ractor: A 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide Hospital or To the Hospital within 24 hours a To the Funeral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b Signat WS 4003 2003 and address of person who completed cause of death (Item 23a) (Type, Print) 10

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

1 5 2005

21157

KEVIN BREWSTER, D.O. 686-C POOLE RD. WESTMINSTER,

32. Registrar's Signature

			1 - For State Ragistrar	State of M	larylan		artment of F		and Mental		ne N200	5 25294	
	Dhusisi		1. Decedent's Name (First, Middle, La	st)					2. Date of	f Death		3. Time of Death	
	Physici /Medi		Ruth Decker DeMo	ouy						17,	2005	8:15 P M	1
	Examir	ier	4a. Facility Name (If not institution, given	re street and number)		4b. City, Town, o	r Location	of Death		4c. County of [Death	
			Raphael House 5. Social Security Number 6.5	Sex 7. A	no /In vre	last birthday)	Rockv		24 Hrs. I a Date a	4 Dieth	Monto	omery	_
	Funeral Director			1□ M 2☐ F	86	Yrs.	Months Days	Hours	Min. 8. Date of (Month)	, Day, Ye	918 C	Birthplace (State or Foreign Country) Klahoma	n
			Usual Residence of Decedent									ATAHOMA	_
	anylar show	_	10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits	
	86-1-08	Director	Maryland Montgor	nery	Ro	ckvill						1 X Yes 2 No	1
	with th		10e. Street and Number				10f. Zip Code			10g.	Citizen of Wha	at Country?	
	72 hours after death with the Maryland natural; or items 23a or 28e-f ehow dieal Exentrat must be neilfied at	Funeral	1515 Dunster Ro	12. Was Deceden	t Ever in II	S 13 1	20854	icoanio Ori	inin? (Specify Vec.)	r No	USA 14 Page	American Indian.	_
(0	r Iten	E I	1 Never Married 2 Married	Armed Forces	?				igin? (Specify Yes on, Puerto Rican, etc.	.)	Black, V	White, etc.	
93	ral', o	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2X No	Specify:			Specify: W	Mhite	
21215-0036	within 72 ho jene. r than "natur rre Madical	Completed	15. Decedent's E (Specify only highest gr			16a. Dece	dent's Usual Occup	ation	t of working	16b	. Kind of Busin	ess/Industry	_
121	within iene. then "	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work done of DO NOT use retired	1)					
	Hyg the nt,		12 17. Father's Name (First, Middle, Las.	*)		Но	memaker	18 Mothe	er's Name (First, Mi	ddlo Maio	Own Ho	me	_
ano	ed tale	To Be	Albert Theodore						sie Mitch		en sumame)		
Maryland	shoul nd Ma mari	ř	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street		er or Rural Route N		lv or Town, Sta	ite. Zip Code)	_
	and 2 ealth a n 27 is		Louis Decker De	Mouy/ Son					e, Chevy				
ore,	S T S T S T S T S T S T S T S T S T S T		20a. Method of Disposition	70		lace of Dispo	sition (Name of matory or other place	:0)	July 22,	20c	Location - Cit	y or Town, State	7
Ĕ	Pages ment of I		1 ⊈Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special Control of Con				ven Cemeter		2005	Sil	lver Sp	ring, Maryland	d
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: if item 27 is marka any injury or raphar traumetic ance.		21. Signature of Funeral Service Lice	nsee .		22 F 5	Name and Address rancis J 00 Unive	ss of Facility	lins Fune Blvd, W,	ral F Silv	dome In Ver Spr	c ing, MD 2090	1
	Pnysician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Severe Due to (or as	_{Norti}	c Sten		g, such as	cardiac or respirato	ry arrest,		Approximate Interval Between Onset and Death	
8760,	cate be executed by yesician and the burial-transit	dlcai Examiner	Sequentially list conditions, 1 any, leading to finith ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Sue to (or as	в в сопворі	uence of):	rdiovascu	ılar 1	Heart Dis	ease			
.O. Box 6	at the death certific by the attending p tached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetel	death 3	Ectopic pregnancy Other (specify)		79734		23d. Date of Month	f delivery Day Year	
ds, P	gned be de	by	Part II. Other significant conditions Dementia, Chroni					en in Part I			co use contribu	te to the cause of death?	1
Ö	law requir as been si 2 should I	olete							24a. \	Vas an	24b. Wer	e autopsy findings available	-
Vital Record	The faw ate has b page 2 st	Completed							_ F	utopsy erformed	? prior deat	r to completion of cause of th?	
ita		BeC	25. Was case referred to medical					26. Place	of Death Check of		No 1		
of V	S D	ToE	examiner? 1 □ Yes 2 □ No	Hospital: 1 Inpati	ient 2	ER/Outpatien	it 3 DOA Othi		rsing Home 5 🗆 f		6 XOther (Assisted Specify) Care	
	ing After une		27. Manner of Death 1 Natural 5 Pending	28a. Date of Inj (Month, Da	ury ay Year)	28b. Time of Injury	Worl	at k?	28d. Descr		njury occurred	Facility	
Sic	Attending ir death. actor: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	e Ogo Diogo of le	Suma. At ho			Yes 2 🗌		(61			
Division	itai or Attend rs after death ai Diractor: , ed in by the f	Certification;	4 Homicide determined		tc. (Specify		eet, factory, office			Town, St		or Rural Route Number,	
	To the Hospital or within 24 hours after To tha Funaral Director completely filled in the funaral of the function of the funct	edical	29a. Certifier 1 St Certifying Pi (Check only one) 2 Medical Exa	nysician: To the best miner: On the basis of and manner s	of examinat	wledge, death tion and/or in	occurred at the time vestigation, in my o	ne, date an pinion, dea	d place, and due to th occurred at the ti	the cause me, date a	ı(s) and manne and place, and	or as stated. due to the cause(s)	
	To T To 1	Σ	29b. Signature and title of certifier	Ø . N	\ M. r	\	29c. License			29d. l	Date signed (M	fonth, Day, Year)	
•	12		PY West 11.	Auare	Zini)	D555	42		Ju	ıly 18,	, 2005	
			30. Name and address of person who Robert Gerard,					Silv	ver Spring	g, MC	20901		
To the same	Sta Registi		31. Date filed (Month, Day, Year)			1.00							

			1 - For State Registrar	State of Mar		artment rtificate				iene 9. 70. 0 0 5	25295
	Physici /Medi Examir	cal	Decedent's Name (First, Middle, Las Margaret Agnes D As Facility Name (If not institution, give 5480 Wisconsin	owd street and number)	2. 821		own, or Loc	cation of Dea	2. Date of Deat Month July 17	Day Yea	8:20 a M
	Funeral Director		5. Social Security Number 6. Security Number 1		(In yrs. last birthday)	If Under 1 Months	Year If	Under 24 Hr lours Mir		0.8	irthplace (State or Foreign Country) elaware
	he Maryland Ba-f show	ector	Usual Residence of Decedent 10a. State Maryland Montgom		0c. City, Town or Lo	Chase					10d. Inside City Limits 1 □ Yes 2 □ No
9	perriit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Departition of Health and Mental Hyglene. Importants if Item 27 is marked other than "natural", or Items 23a or 28a-f show many injury or other traumatic event, the Medical Exaction matter hutilised at Once.	Funeral Director	10e. Street and Number 5480 Wisconsin 11. Marital Status 1 \(\text{Never Married} \) 2 \(\text{Married} \)	Avenue, Apt 12. Was Decedent Ev Amed Forces? 1 Yes 2 No If Yes, Give	er in U.S. 13.		20815 nt of Hispa Cuban, M		Specify Yes or No- into Rican, etc.)	Black, Wh	USA nerican I <i>n</i> dian,
21215-0036	vithin 72 hours ne. han "natural", e Modical Exe	Completed by	3 ☑ Widowed 4 □ Divorced 15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	Year or Dates: ucation de completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual (kind of work DO NOT use	Occupation done during retired)	pecify: n ng most of w	orking	16b. Kind of Busines	s/Industry
Maryland 21	ould be filed w I Mental Hygie wrked other ti	To Be Co	17. Father's Name (First, Middle, Last) Martin Joseph M			nemakeı	18.	Delia	ame (First, Middle, M	1	
, Mar	and 2 sh lealth and m 27 is m her traum		19a. Informant's Name/Relationship (7 Kevin Barry Dowd		17	Infield	d Cou		Rural Route Number, cth, Rocky	ville, MD	20854
Baltimore,	perrit. Pages 1 Department of H Important: If Ite any Injury or otl ance.		20a. Method of Disposition 1 Description 1 Description 2 Cremation 3 Description 4 Donation 5 Description 5 Descr)	20b. Place of Disponsion P	matory or othe Lvet Ce	er place) emete		July 20	Vashingtor	
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or companies to the shock, or heart failure. List only of the shock of heart failure. List only of the shock of heart failure. List only of the shock of the	a. Renal Fa Due to (or as a c Due to (or as a c C.	ailure				d, W, Sil		Approximate Interval Between Onset and Death 1 Month
P.O. Box 68760,	The law requires that the death certificate be executed to has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d	pregnancy □ Fetal death 3 [□Ectopic preg □ Other (spec				23d. Date of d Month	elivery Day Year
Records, F	w requires that been signed I should be det	by	Pad II. Other significant conditions of Chronic Anemia	entributing to death but i	not resulting in the u	nderlying cau	sa given in	i Part I.	1 □ Ye	s 2 √ No 3 ∏	to the cause of death? Probably 4 Dunknown
		e Completed	25. Was case referred to medical				00	Diana of Da	24a. Was ar autopsy perform 1 Yes 2	prior to death? No 1 Ye	
vision of	tending Physicath.	Certification; To B	examiner?	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Y) 28e. Place of Injury building, etc.	28b. Time o Injury	f 28c	Other: 2 Injury at Work? 1 Yes		Home 5X Reside 28d. Describe ho	nce 6 Other (Sp w injury occurred	
۵	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical Cer	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	vsician: To the best of iner: On the basis of ex	my knowledge, deat	h occurred at vestigation, in	the time, o	fate and place	e, and due to the ca	use(s) and manner	as stated.
1	To the within ?	Мес	29b. Signature and title of certifier of Durry 30. Name and address of erson who describes the second secon	and manner state	NA		icense nu 30036			Od. Date signed (Mor	
	Sta		Barry George Sim 31. Date filed (Month, Day, Year) JUL 19 216	on, M.D. S	5530 Wisco		Avenu	e, #80	00, Chevy	Chase, MI	20815

ren's		1 - For State Registrar	State of Maryland / Do	epartment of F Certificate of				
Physici	an ·	1. Decedent's Name (First, Middle, Last) Eugene			ans	2. Date of Dea Month	Day Yeer	2 Time of Death 5
/Medic		4a. Facility Name (If not institution, give s.	treet and number)		or Location of Death	July	4c. County of Dea	
EXGITI	36	The Johns	Hopkins Hospita	1	timore C	ity		
. Funeral Director		419-42-0020	M 2 F 7. Age (In yrs. last birth	Months Days	Hours Min.	8. Date of Birtl (Month, Day Nov. 1,	9. Bi 1932 Ala	rthplace (State or Foreign ountry) bama
/land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
e Man ta-fsh Liftied	ctor	Maryland Prince Geo	rge Distri	ct Heights				1⊠Yes 2□No
death with the Maryland ms 23s or 28a-f show Frount be notified at	Director	10e. Street and Number 1310 Iron Forge R	oad	10f. Zip Code	20747		10g. Citizen of What C United Sta	
death ms 23	Funerai		2. Was Decedent Ever in U.S.	13. Was Decedent of H				erican Indian,
ING Z IZ 13-0030 be filed within 72 hours after death with the Marylan tal Hyglene ad other than "natural", or flems 23s or 28a-1 show event, the Medical Examinar must be redified at	by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 XYes 2 No 1953 If Yes, Give to 1973 Year or Dates:	1 ☐ Yes 2 No	Specify:	Rican, etc.)	Black, Wh	
72 ho	eted	15. Decedent's Educ (Specify only highest grade	completed) (Decedent's Usual Occur Give kind of work done	during most of worki	ing	16b. Kind of Business	
filed within if I Hygiene. Other than "rent, the Medient,	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	ife. DO NOT use retire al Employme	•	nity Mans	Co	ederal vernment
and and and and and and and and and and	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name		Maiden Sumame)	
should by nd Menta marked umatic ev	ပ	Neale Evans, Sr. 19a. Informant's Name/Relationship (Type	on Christ	4-15- Add (Ot	Marie T			
2 6 5 6		Evangeline Evans/S		Mailing Address (Street				
ore, IV		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re	20b. Place of E cemetery,	Disposition (Name of crematory or other pla	ce)	Date	20c. Location - City of	Town, State
Daltimor permit. Pages Department of Important: If it any injury or o		*4 ☐ Donation 5 ☐ Other (Specify)	Arlingt	on National			Arlington	, VA.
Dermi Departiment of the policy of the polic		21. Signatur neral Service License		22. Name and Addre	55	38 Marl	ral Homes loro like le, MD. 2	0747
		23a. Part1. Enter the diseas or complex shock, or heart failurs. List only on	ations that used the death. Do no	I It enter the mode of dyi	The second secon			Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	Lungcand					Onset and Death
/Medical Examiner		resoluting in dealiny	Due to (or as a masequence of):				,
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):				
cate be executed physician and the burial-transit	Examine	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequence of).				
ate be exphysician the buria	dicai E	L _d	250 10 (01 00 0 0011304251100 01	,·				
5 8	0	IF FEMALE:						
atte for	ician/M	23b. Was decedent pregnant in the past 12 months?	dc. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death	3 □Ectopic pregnance 5 □ Other (specify)	у		23d. Date of de Month	livery Day Year
the cy the ached	hys	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	5 Uther (specify)				
w requires that the been signed by the should be detached	by P	Part II. Other significant conditions conf	tributing to death but not resulting in t	he underlying cause gr	ven in Part I.	X .	bacco use contribute t	
law requires the sas been signed as been signed as been signed being the same and being the same are same as been signed being the same are same as been signed being the same are same as been signed being the same are same as been signed being the same are same as been signed being the same are same as been signed to same as the same as t	eted					1,2%		robably 4 Unknown
ne The la te has age 2	ompleted					24a. Was a autop: perfor	sy prior to death?	utopsy findings available completion of cause of
	Bec	25. Was case referred to medical examiner?			26. Place of Death			s 2□ No
Phys this ral dir	ို	1 ☐ Yes 2 ☐ No 27. Manner of Death	ospital: 1 Inpatient 2 ER/Outp 28a. Date of Injury 28b. Tir		4 LINUISING HO		ence 6 Other (Spe	ecify)
Attending Physer death. ector: After this oby the funeral dr	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Inj	ury Wo	rk? Yes 2 □ No	200. Describe (1	ow injury occurred	
or Attender ter death irector:	ertification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office		28f. Location (S City or Tow	itreet and Number or A n, State)	ural Route Number,
epital or ours afte neral Dir filled in	O	29a. Certifier 12 Certifying Physic	icien: To the best of my knowledge,	death occurred at the fi	me date and place	and due to the	azueo(e) and manage	c stated
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the tu	edical	(Check only 2 Medicel Examin one)	er: On the basis of examination and/ and manner stated.	or investigation, in my	opinion, death occurre	od at the time, o	date and place, and du	e to the cause(s)
Tot Within	M	29b. Signature and title of certifier	<i>M</i> .	29c. Licens			29d. Date signed (Mon	
iva		30. Name and address of person who cert	Many M	O Re	5-000		July8,	2005
33		Naveen Pemmas	aju, the Johns	Heplans He	=p.tal,60	ONOrth	Woi fe Street	Baltimore MD 21287
Sta Registi		31. Date filed (Month, Day, Year)	npleted cause of double (Item 23a) (The Johns 32. Registrar's Signature	,				

State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	Reg. No. 2005 2520
Physiciar		2. Date of Deeth Month Day Year 3. Time of Death
/ /Medica		July 19, 2005 5:45am
Examine	4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Loc	
	Charles County Nursing & Rehab LaPlata 5. Social Security Number 6. Sex 7. Ang. (In vrs. lest hithdray) 1 Under 1 Year 1 Under 24 Hrs.	Charles
Funeral Director	570 50 00/1 1 M 2XIF Q/i Vrs Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Sarch 14,1911 Puerto Ri
fand	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Mery Est	MD Charles LaPlata	11∕2 Yes 2 □ No
vith the Me n or 28a-f s be notified	10e. Street end Number 10f. Zip Code	10g. Citizen of What Country?
3a o	205 Morgans Ridge Ct. 20646	USA
r items 23a	11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Ves., specify Cuban, Mexican, Puerto R	eify Yes or No- 14. Race - American Indian,
If, o	If Yes, Give A Year or Dates:	to- Specify: White
2 hor	15. Decedent's Education 16e. Decedent's Usual Occupation	16b. Kind of Business/Industry
- 1 24	(Specify only highest grede completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	
d withir giene.	12 Assistant to Direct	or Dept. of Publicati
tel Hy d othe		(First, Middle, Maiden Surname)
	Felix Suarez Louisa	Martinez
d 2 should the end Men 7 is marke traumatic.	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural	Route Number, City or Town, State, Zip Code)
and saith	Elaine Lawton/Niece 205 Morgans Ridge C	t. La Plata MD 20646
of He	20a. Method of Disposition 20b. Place of Disposition (Name of	Date 20c. Location - City or Town, State
Page ent cent ry or	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1 A Donation 5 Other (Specify) 1 A Donation 5 Other (Specify)	22/05 Silver Spring,MD
permit. Pages 1 and Department of Health Important: if Item 27 any Injury or other ti ance.	1	FUNERAL HOME, P.A.
Dem Depe Impo any i		A PLATA, MD. 20646
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	
Physician		Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition entertain condition entertain disease or condition entertain disease or condition	4
	Due to (or as a consequence of):	1
Sit ad	_ h	
end -tren	Sequentially list conditions, if any leading to immediate	
cien cien	Sequentially list conditions, if eny, leading to immediate cause. Enter Undertying Cause (Disease or injury	
The law requires that the deeth certificate be executed ate has been signed by the ettending physicien end page 2 should be deteched for use as the buniel-trensit completed by Physician/Medical Examiner	that initiated events resulting in death) Last Due to (or as e consequence of):	
ding I	d.	
eth c		
v requires thet the deeth ce been signed by the ettend should be deteched for us.	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death?
d by detec		1 Yes 2 No 3 Probably 4 Unknow
The law requires the set of the s		
een hould		24a. Was an autopsy performed? 24b. Ware autopsy findings available prior to completion of cause
law ies b	W. div C. Juliano	of death?
Page Co		1 Yes 2 1 Yes 2 No
clan: ertific actor,	25. Was case referred to medical 26. Place of Death (examiner?	(Check only one)
Physician: r this certific and director,		e 5 ☐ Residence 6 ☐ Other (Specify)
fter the mera	27. Manner of Deeth 28e. Dete of Injury 28b. Time of 28c. Injury at Work? 28b. Natural 5 ☐ Pending (Month, Dey Year) 28b. Time of 1njury 28b. Time of 28c. Injury at Work?	3d. Describe how injury occurred
death.	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No	
tal or Attending P rs effer death. al Director: After t led in by the funers Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28	Bf. Location (Street and Number or Rural Route Number, City or Town, Stete)
Se et al constant de la constant de	v	
To the Hospital or Attending Physician: The law within 24 hours efter death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	29a. Certifier (Check only (Ch	nd due to the cause(s) and manner as stated.
the F the F nplet	one) and manner stated.	
With To to to to to to to to to to to to to to	29b. Signature and one of certifier 29c. License number	29d. Date signed (Month, Day, Year)
	Mouthberry 10 00040479	7/19/05
08 in	30. Neme end address of person who completed cause of death (Item 3e) (Type, Print) Robert Davison, Jr., M.D. 12070 Old Line Center	20602 ,Suitel00,Waldorf,MD
State	31. Date filed (Month, Day, Year) 32. Pagistrar's Signature	
Registrar	JUL 2 0 2005 Mayor & Speaked	

DHMH 16 Rev 6/95

			1 - For State Registrar	State of N	/larylan		artment tificate			ind M		Reg. No.	0.05	25298
)	Physici /Medi Examir	cal	4a. Facility Name (If not institution,	Ederma give street and numbe	r)		4b. City, 1		Location o		2. Date of Dea	7, Day 20	ounty of Death	
	Funeral Director		213-30-7758		Age (In yrs. I	last birthday) 83 Yrs.	If Under Months		kvill If Under 2 Hours		8. Date of Birt (Month, Day May 4,	h V. Year)	ontgome 9. Birth Con Est	ery nplace (State or Foreign untry) onia
	the Maryland 28a-f show	Director	Usual Residence of Decedent	omery		, Town or Lo		Code				10g Citizar	n of What Co	10d. Inside City Limits 1 ☑Yes 2 ☐ No
36	s within 72 hours after death with the Maryland liene. r than "naturel", or Items 23e or 28e-f show the Medical Examinar must be rigitified at	by Funeral Di	9701 Veirs Dri 11. Marital Status 1 Never Married 2 Marrier Widowed 4 Divorced	12. Was Deceder Armed Forces	s?			208 ent of His fy Cubar		jin? (Spe , Puerto l	cify Yes or No- Rican, etc.)	14.	Race - Amer Black, White	ncan Indian, , etc.
Maryland 21215-0036	s within jiene. r than "	ompieted	15. Decedent's (Specify onfy highest Elementary/Secondary (0-12)	Education		16a. Deced (Give life. L		l Occupa k done d e retired)	tion uring most	of workir	ng	16b, Kind	of Business/l	
yland	lec Tr.	To Be C	17. Father's Name (First, Middle, La John Ederma						K1a	ra M	(First, Middle,	eil		
	1 and 2 Health a am 27 is ther trai		19a. Informant's Name/Relationship Kristina Hughe 20a. Method of Disposition		20b. PI	970 lace of Dispos	1 Vei	rs D	rive	Rock	Route Numbe	MD 2	own, State, Z 20850 tion - City or 1	
Baltimore,	t. P rtme rtan riur)		1 ☐ Burial 2 ② Cremation 3 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Up	city)	.0	emetery, cren ropoli 22		rema	tory		9-05		andria	
ä	Departing Department of the policy of the po		23a. Part1. Enter the disease, or conshock, or heart failure. List or	omolications that caus	ed the death line.			651	0 16t	h St	. NW Wa		gton, l	Approximate Interval Between
	death certificate be executed /Medical mand e attending physician and for use as the burial-transit	licai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to minimulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	MONA as a consequ ASTA as a consequ as a consequ	Jence of):			5710		TNCET			Onset and Death FLW MINUTES
.O. Box 6	death certifi e attending id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 🗌 Fetal	death 3	Ectopic pre					23d	I. Date of delin	very Day Year
ords, P	w requires that the been signed by th should be detache	by	Part II. Other significant condition	s contributing to death	but not resu	ılting in the ur	nderlying ca	use give	n in Part I.			bacco use		the cause of death?
of Vital Record	The law ate has b page 2 st	e Completed	25. Was case referred to medical								24a. Was a autops perform	sy med? 2.⊠No	prior to co death?	opsy findings available ompletion of cause of
Division of Vil	ding Phya I. After this funeral di	ertification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigal	28a. Date of In (Month, D	iury	ER/Outpatient 28b. Time of Injury		c. Injury Work	r: 4 Nur	sing Horr	(Check only or ne 5 ☐ Reside 8d. Describe he	ence 6		ity)
Divi	Hospital or Attend 24 hours after deatl Funaral Diractor: stely filled in by the	O	3 Suicide 6 Could not determine 29a. Certifier 1 Certifying	building,	etc. (<i>Specify</i> ,	·)					City or Tow	n, State)		al Route Number,
41/1	To the Hos. within 24 ho To tha Fun completely f	Medical	(Check only 2 Medical Expone) 29b. Signature and title of certifier 30. Name and address of person with the control of the c		of examination of exa	M D 23a) (Type, I	29c. Print)	License	number	S C	d at the time, d	ate and pla	igned (Month,	Day, Year)
1 4	Sta Registr	-	31. Date filed (Month, Day, Year) JUL 2 0 200	\$2. Regis	to de Official	UF SORA	DRI	VE		100	KUILL	. U	11020	850

			1 - For State Registrar		State of N	Marylar		artment o <i>rtificate (</i>			-	•		7 0 000	<i>(</i>) <i>(</i>) <i>(</i>
			Hegistrar Decedent's Name (First,	Middle, Las	st)			tinouto (51 DOU		2. Date of De	Rag. No	2005	9. Time	of Death
	Physici		Alice		Ey1e	r					Month July	19, Da	y 2005	2:0	2 P M
	/Medic Examin		4a. Facility Name (If not ins	stitution, give				4b. City, Tow	vn, or Locati	on of Death	oury		. County of De		<u></u>
		<u>.</u>	Glade Valley	Nurs	ing and H	Rehabi	litati	on Wa	alkers	sville			Frede	rick	
	Funeral		5. Social Security Number	6. S	ex 7.	Age (In yrs.	last birthday)	If Under 1 Y		der 24 Hrs.	8. Date of Bir (Month, Da	th y, Year)	9. E	Birthplace (Star	te or Foreign
	Director		218-24-9836		□ M 2 Ø F	77	Yrs.				July 1	, 19	28 Mai	cyland	
	and and	}	Usual Residence of Deced 10a. State 10b. 0	County		10c. Cit	ty, Town or Lo	ocation						10d. Inside	City Limits
	e-f sho	ctor	Maryland Fr	ederio	ck	W	alkers	ville						1 🗆 Y	es 2 No
	permil. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Iteme 23a or 28e-f show amy original examination of the theory or other traumatic event, the Medical Examination to Inditional anongo.	by Funeral Director	10e. Street and Number 9746 Daysvi	11e Ro	oad			10f. Zip Cod 2179					tizen of What	Country?	
	death	nera	11. Marital Status		12. Was Decede	nt Ever in U	l.S. 13.	Was Decedent	of Hispanio	Origin? (Sp	ecify Yes or No Rican, etc.)	>-		nerican Indian	,
936	urs after el', or Ite	by Fu	1 Never Married 2[3 ☐ Widowed 4 ☐ Div		Armed Force 1 Tyes 2 If Yes, Give Year or Date:	No	ĺ	1 ☐ Yes 2 🕞			rican, etc.)		Black, Wi	white	i
21215-0036	n 72 ho "nature edical l	Completed	(Specify only		de completed)		16a. Dece (Give	dent's Usual Oo kind of work do DO NOT use re	ccupation lone during i etired)	most of work	ing	16b. K	ind of Busines	ss/Industry	
212	withi	mo	Elementary/Secondary (0-12)	College (1-4d	or 5+)	Babys		,			c	hild ca	are	
	should be filed within and Mental Hygiene. s marked other then " umatic event, the Men	a	17. Father's Name (First, M	Aiddle, Last)			120270		18. M	other's Name	e (First, Middle				
<u>lar</u>	uld be Aenta rked rked tic ev	To B	James Albe	rt Ey	ler				Ann	a Mary	Irene	Ken	ney		
Maryland	trauma		19a. Informant's Name/Re Peggy Eyler								1 Route Number 1 1 Route				793
ē,	permil. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tra once.		20a. Method of Disposition			20b. F		osition (Name o			Date		ocation - City		
Baltimore,	Pages ent of nt: If i		1 ☑ Burial 2 ☐ Crem 1 ☑ Donation 5 ☐ Of					1 Cemet		July 2	3, 200	Wo	odsboro	, Mary	1and
alti.	permil. Page Department (Importent: II any injury or once.		21. Signature of Funeral S			100		2. Name and A			auffer				
Ö	Depar Impo any ir		esharow.	Canu	The Co	line	2 4	0 Fulto	n Ave		alkersy				1793
	*		23a. Part1. Enter the diseashock, or heart failure	ase, or comp	plications that caus	sed the deat									
8			1 11 . 40 /401 1	e. List offin	one cause on each	line.	th. Do not ent	er the mode of	dying, such	400	_			Approxir Interval I Onset ar	Between
	Physician /Modical		Immediate Cause (Final disease or condition resulting in death)	e. List only	a C	-0n9 -0n9	المائح	er the mode of		400	or respiratory a			Interval I	Between nd Death
	Physician /Medical Examiner			e. List only	a C	as a cons	المائح			400	_			Interval I Onset a	Between nd Death
	/Medical	ier	disease or condition resulting in death)	(aDue to (or	-0n9 -0n9	quence of):			400	_			Interval I Onset a	Between nd Death
	/Medical Examiner	ıminer	disease or condition resulting in death) Sequentially list conditions if any, leading to immediate the cause Disease or ringery	(aDue to (or	as a cons	quence of):			400	_			Interval I Onset a	Between nd Death
	/Medical Examiner	Examiner	disease or condition resulting in death) Sequentially list conditions if any, leading to immediat	(a	as a cons	quence of):			400	_			Interval I Onset a	Between nd Death
	/Medical Examiner	ical	disease or condition resulting in death) Sequentially list conditions if any, leading to immediate the conditions of th	(a	as a consec	quence of):			400	_			Interval I Onset a	Between nd Death
68760,	/Medical Examiner	ical	disease or condition resulting in death) Sequentially list conditions if any, leading to immediat cause. Enter the conditions in the cause (Disease or injury that initiated events resulting in death) Last	(a	as a consec as a consec as a consec	quence of):			400	_			Interval I Onset a	Between nd Death
. Box 68760,	death certificate be executed was as the burial-transit	ical	disease or condition resulting in death) Sequentially list conditions if any, leading to immediate the conditions of th	s. See	a	as a consecutive of pregn. 2 Feta tat time of c	quence of): quence of): ancy al death 3 [nancy	400	_	re	23d. Date of o	Interval I	Between nd Death
P.O. Box 68760,	death certificate be executed was as the burial-transit	Physiclan/Medical	disease or condition resulting in death) Sequentially list conditions if any, leading to immediate the cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregn. in the past 12 months 1 yes 2 1 No	ant	a	as a consection of pregnatic at time of consections.	quence of): quence of): quence of): quence of):	Ectopic pregn	iancy	<i>→ I</i>	Sul us	re		Onset aid	Batween and Death Co
P.O. Box 68760,	death certificate be executed was as the burial-transit	by Physiclan/Medical	disease or condition resulting in death) Sequentially list conditions if any, leading to immediate the sequence of the sequen	ant	a	as a consection of pregnatic at time of consections.	quence of): quence of): quence of): quence of):	Ectopic pregn	iancy	<i>→ I</i>	Sul us	robacco	Month use contribute	Onset aid	Year
P.O. Box 68760,	rrequires that the death certificate be executed The attending physician and should be detached for use as the burial-transit	by Physiclan/Medical	disease or condition resulting in death) Sequentially list conditions if any, leading to immediate the sequence of the sequen	ant	a	as a consection of pregnatic at time of consections.	quence of): quence of): quence of): quence of):	Ectopic pregn	iancy	<i>→ I</i>	23e. Did t	cobacco Yes 2	Month use contribute No 3 24b. Were	delivery Day to the cause of Probably 4 autopsy findin	Year Of death? Unknown
Records, P.O. Box 68760,	e law requires that the death certificate be executed has been signed by the attending physician and has been signed by the attending physician and has been signed by the attending physician and has been signed.	by Physiclan/Medical	disease or condition resulting in death) Sequentially list conditions if any, leading to immediate the sequence of the sequen	ant	a	as a consection of pregnatic at time of consections.	quence of): quence of): quence of): quence of):	Ectopic pregn	iancy	<i>→ I</i>	23e. Did t 1	obacco Yes 2	Month use contribute No 3 24b. Were prior to death	delivery Day to the cause of Probably 4 autopsy finding of completion of 2	Year Of death? Unknown
Records, P.O. Box 68760,	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	e Completed by Physiclan/Medical	disease or condition resulting in death) Sequentially list conditions if any, leading to immediate the sequence of the sequen	ant	a	as a consection of pregnatic at time of consections.	quence of): quence of): quence of): quence of):	Ectopic pregn	iancy b) e given in P	art I.	23e. Did t	obacco Yes 2 an psy primed2 21 No	Month use contribute No 3 24b. Were prior to death	delivery Day to the cause of Probably 4 autopsy finding of completion of 2	Year Of death? Unknown
Vital Records, P.O. Box 68760,	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Be Completed by Physiclan/Medical	disease or condition resulting in death) Sequentially list conditions if any, leading to immediate the sequence of the sequen	ant	a	as a consection as a consectin as a consection as a consection as a consection as a consection	quence of): quence of): quence of): quence of):	DEctopic pregn Dother (specify	nancy y) e given in P	art I.	23e. Did t 1 24a. Was auto; perfo	obacco Yes 2 an psy pred 2 2 No	Month use contribute No 3 24b. Were prior to death	delivery Day to the cause of Probably 4 autopsy finding of completion of 2 es 2 \(\subseteq \) No	Year Of death? Unknown
of Vital Records, P.O. Box 68760,	Physicien: The law requires that the death certificate be executed the state of the	To Be Completed by Physiclan/Medical	disease or condition resulting in death) Sequentially list conditions if any, leading to immediate the sequence of the sequen	ant s?	a	as a consection as a consectin as a consection as a consection as a consection as a consection	quence of): quence of): quence of): ancy al death feath feath for the unit of	Ectopic pregn Other (specify nderlying cause	nancy y) e given in P	art I.	23e. Did t 1 24a. Was auto; perfo	obacco Yes 2 an psy pred2 212 No	Month use contribute No 3 □ 24b. Were prior t death 1 □ Y. 6 □ Other (S)	delivery Day to the cause of Probably 4 autopsy finding of completion of 2 es 2 \(\subseteq \) No	Year Of death? Unknown
of Vital Records, P.O. Box 68760,	ng Physicien: The law requires that the death certificate be executed the result of th	To Be Completed by Physiclan/Medical	disease or condition resulting in death) Sequentially list conditions if any, leading to immediate the sequence of the sequen	ant s?	a	as a consection as a consectio	quence of): quence of): quence of): ancy al death 55 death 55 death 55 ER/Outpatier 28b. Time o	DEctopic pregn Other (specify and substitution of the control of t	ancy y) e given in P 26. F Other: 4 Injury at Work? 1 □ Yes:	art I.	23e. Did t 1 24a. Was auto perfo 1 Yes n (Check only o	cobacco Yes 2 an psy 22 No one) dence how inju	Month use contribute No 3 □ 24b. Were prior t death 1 □ Y 6 □ Other (S) ry occurred	delivery Day to the cause of Probably 4 autopsy finding of completion of 2 es 2 \(\text{No} \)	Year Year Of death? Unknown gs available of cause of
of Vital Records, P.O. Box 68760,	ng Physicien: The law requires that the death certificate be executed the result of th	To Be Completed by Physiclan/Medical	disease or condition resulting in death) Sequentially list conditions if any, leading to immediate the sequence of the sequen	ant s?	a	as a consection as a consectio	quence of): quence of): quence of): ancy al death feath feath feath Sulting in the u Calculation Calcul	Dectopic pregn Other (specify and arriving cause of the control of	ancy y) e given in P 26. F Other: 4 Injury at Work? 1 □ Yes:	art I.	23e. Did t 1 24a. Was auto; perfo 1 Yes n (Check only o	obacco Yes 2 an psy ormed2 2(2) No one) dence how inju	Month use contribute No 3 24b. Were prior t death 1 Y 6 Other (S) ry occurred	delivery Day to the cause of Probably 4 autopsy finding of completion of 2 es 2 \(\text{No} \)	Year Year Of death? Unknown gs available of cause of
of Vital Records, P.O. Box 68760,	ng Physicien: The law requires that the death certificate be executed the result of th	To Be Completed by Physiclan/Medical	disease or condition resulting in death) Sequentially list conditions if any, leading to immediate the sequence of the sequen	ant 5? conditions con	a	as a consection as a consectio	quence of): quence of): quence of): ancy al death death feath Sulting in the unit of t	Dectopic pregn Other (specify and 3 DOA) of 28c.	ancy y) e given in P 26. F Other: 4 Injury at Work? 1 □ Yes:	art I. Place of Deati Nursing Ho 2 \(\subseteq No \)	23e. Did t 1 24a. Was auto; perfo 1 Yes 1 (Check only of the control of the contr	an psy 2 2 Noone) dence how inju	Month use contribute No 3 □ 24b. Were prior t death 1 □ Y 6 □ Other (S) ry occurred and Number or a)	delivery Day to the cause of Probably 4 autopsy finding of completion of each of the cause of the completion of the cause	Year Year Of death? Unknown gs available of cause of
of Vital Records, P.O. Box 68760,	ng Physicien: The law requires that the death certificate be executed the result of th	Be Completed by Physiclan/Medical	disease or condition resulting in death) Sequentially list conditions if any, leading to immediate the sequence of the sequen	ant 5? conditions con	a. Due to (or b. Due to (or c. Due to (or d. 23c. If yes, outcor 1 Live birth 4 Pregnant 9 Unknowr ontributing to deatl Republication 28a. Date of li (Month, or 28b. Place of building, ysician: To the besiner: On the basis	as a consection as a consectio	quence of): quence of): quence of): ancy al death death feath Sulting in the unit of t	Dectopic pregn Other (specify of the specify of the specific of the speci	ancy y) e given in P 26. F Other: 4 Injury at Work? 1 □ Yes:	art I.	23e. Did t 1 24a. Was auto; perfo 1 Yes 1 (Check only of the control of the contr	obacco Yes 2 an psy remod? 22 No one) dence how inju Street ar wn, State cause(s date an	Month use contribute No 3 □ 24b. Were prior t death 1 □ Y 6 □ Other (S) ry occurred and Number or a)	delivery Day to the cause of Probably 4 autopsy finding of completion of Probably 4 autopsy finding of completion of Probably 4 autopsy finding of completion of Probably 4 autopsy finding of completion of Probably 4 autopsy finding of Probabl	Year Year Of death? Umber, Implementation of the course of the cours
of Vital Records, P.O. Box 68760,	the Hospitel or Attending Physicien: The law requires that the death certificate be executed in 24 hours after death. The Ab hours after death. The Funerel Director: After this certificate has been signed by the attending physician and the Funerel Director: After this certificate has been signed by the attending physician and in properties of the funeral director, page 2 should be detached for use as the burial-transit in properties of the funeral director, page 2 should be detached for use as the burial-transit.	edical Certification: To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions if any, leading to immediate the sequence of the sequen	ant s? conditions c pending investigation Could not be determined ertifying Phedical Exam	a. Due to (or b. Due to (or c. Due to (or d. 23c. If yes, outcor 1 Live birth 4 Pregnant 9 Unknowr ontributing to deatl Republication 28a. Date of li (Month, or 28b. Place of building, ysician: To the besiner: On the basis	as a consection as a consectio	quence of): quence of): quence of): ancy al death death feath Sulting in the unit of t	Dectopic pregn Other (specify of the specify of the specific of the speci	ancy y) e given in P 26. P Other: Work? 1 Yes: ffice	art I.	23e. Did t 1 24a. Was auto; perfo 1 Yes 1 (Check only of the control of the contr	obacco Yes 2 an psy remod? 22 No one) dence how inju Street ar wn, State cause(s date an	Month use contribute No 3 24b. Were prior to death 1 Y 6 Other (S) ry occurred and Number or and place, and described to the contribute of the con	delivery Day to the cause of Probably 4 autopsy finding of completion of Probably 4 autopsy finding of completion of Probably 4 autopsy finding of completion of Probably 4 autopsy finding of completion of Probably 4 autopsy finding of Probabl	Year Year Of death? Umber, Implementation of the course of the cours
of Vital Records, P.O. Box 68760,	ng Physicien: The law requires that the death certificate be executed the result of th	edical Certification: To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions if any, leading to immediate the sequence of the sequen	ant s? conditions con	a. Due to (or b. Due to (or c. Due to (or d. d. 23c. If yes, outcor 1 Live birth 4 Pregnant 9 Unknowr ontributing to deatl A C C Hospital: 1 Inp. 28a. Date of Inf. 28b. Place of building, ysician: To the basis and manner	as a consect as a consect as a consect at time of pregnatat time of consect at time of co	quence of): quence of): quence of): quence of): ancy al death feath	Dectopic pregn Other (specify and all all all all all all all all all al	ancy y) e given in P 26. P Other: Work? 1 Yes: ffice	art I. Place of Death Nursing Ho 2 \(\text{No} \) e and place, death occurrence.	23e. Did to the ed at the time,	obacco Yes 2 an promed? 2(1) No one) dence how inju Street ar wn, State cause(s date an 29d. Da	Month use contribute No 3 24b. Were prior to death 1 Y. 6 Other (S) ry occurred and Number or a) and manner of place, and dotte signed (Monta)	delivery Day to the cause of Probably 4 autopsy finding of completion of Probably 4 autopsy finding of completion of Probably 4 autopsy finding of completion of Probably 4 autopsy finding of completion of Probably 4 autopsy finding of Probabl	Year Year Of death? Umber, Implementation of the course of the cours
of Vital Records, P.O. Box 68760,	ng Physicien: The law requires that the death certificate be executed the result of th	edical Certification: To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions if any, leading to immediate the sequence of the sequen	ant s? conditions con	a. Due to (or b. Due to (or c. Due to (or d. d. 23c. If yes, outcor 1 Live birth 4 Pregnant 9 Unknowr ontributing to deatl A C C Hospital: 1 Inp. 28a. Date of Inf. 28b. Place of building, ysician: To the basis and manner	as a consect as a consect as a consect at time of pregnatat time of consect at time of co	quence of): quence of): quence of): quence of): ancy al death feath	Dectopic pregn Other (specify and all all all all all all all all all al	ancy y) e given in P 26. P Other: Work? 1 Yes: ffice	art I. Place of Death Nursing Ho 2 \(\text{No} \) e and place, death occurrence.	23e. Did t 1 24a. Was auto; perfo 1 Yes 1 (Check only of the control of the contr	obacco Yes 2 an promed? 2(1) No one) dence how inju Street ar wn, State cause(s date an 29d. Da	Month use contribute No 3 24b. Were prior to death 1 Y. 6 Other (S) ry occurred and Number or a) and manner of place, and dotte signed (Monta)	delivery Day to the cause of Probably 4 autopsy finding of completion of Probably 4 autopsy finding of completion of Probably 4 autopsy finding of completion of Probably 4 autopsy finding of completion of Probably 4 autopsy finding of Probabl	Year Year Of death? Umber, Implementation of the course of the cours

			1 - For State Registrar	State of M	laryland / De	partment of <i>ertificate o</i>				giene Reg. N	005	253	nn
П	Physici	an	1. Decedent's Name (First, Middle, La	1					2. Date of De	eath	Year	3. Time of	Death
	/Medic		JOSep		zinger				July	1 ^{Day}	2005	9:15	A ^M
	Examir	er	4a. Facility Name (If not institution, give				, or Location of	of Death		4c. Co	ounty of Deat	h	
	Formula		Anne Arundel Med: 5. Social Security Number 6.5		ge (In yrs. last birtho	Annap av) If Under 1 Ye		24 Hrs o	Data of Bir		ne Art		
	Funeral Director			M 2□F	84 Yrs	Months Day	rs Hours	Min.	Month, Da	ay, Year) 26.1	9. BIR	nplace (State or untry)	r Foreign
	P _		Usual Residence of Decedent						Sept.	20, 1	.940 .	ndiana	
	show	-	10a. State 10b. County		10c. City, Town o	Location						10d. Inside Cit	
	Ne M	Director	Maryland Anne A	rundel	Annapo1				1			1 🗌 Yes	2 XX N0
	with			# .		10f. Zip Code				_	n of What Co	1	
	na 23	Funeral	2058 Quaker Way	FIA 12. Was Deceden	t Ever in U.S.	3 Was Decedent of		nin? (Speci	fy Yes or No		d Stat		
မွ	or iter	Fun	1 ☐ Never Married 2 ☑ Married	Armed Forces 1 Tes, Give	?	Was Decedent of If Yes, specify Communication		, Puerto Ri	can, etc.)		Black, White		
03	72 hours after death with the Maryland Insture!', or Itema 23a or 28a-1 show digal Examilinar must be notified at	ı by	3 Widowed 4 Divorced	If Tes, Give Year or Dates:	1943-1946	1 ☐ Yes 2 🙀 N	lo Specify:			Sp	ecify: wh	ite	
21215-0036	"natu	Completed	15. Decedent's E (Specify only highest gra		16a. De	cedent's Usual Occive kind of work dor 5. DO NOT use reti	upation e during most	t of working	,	16b. Kind	of Business/l	ndustry	
121	within ene. than "	mp	Elementary/Secondary (0-12)	College (1-4or	5+)		red)						
9	e filed al Hygie other vent, L	e Co	17. Father's Name (First, Middle, Last)	M	achinist	18 Mothe	r's Name //	First, Middle		al Aca	demy	
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylar It of Health and Mental Hygiene. If item 27 is marked other than "natural", or itema 23a or 28a-1 show or other traumatic event, the Medical Example or must be notified at	To B	Joseph Sebastian					Morr		, maidon da	mamoy		
ary	2 should be and Mental Is marked sumatic ev	_	19a. Informant's Name/Relationship (19b. M	ailing Address (Stre	et and Numbe	r or Rural F	Route Numb	er, City or To	own, State, Z	ip Code)	
Σ	1 and 2 Health a sm 27 Is		Steve Enzinger/	son		Wind Whis							
ore	of He of He fiten		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State		sposition (Name of rematory or other p	lace)	Dat	е	20c. Locat	ion - City or T	Town, State	
Ë	mit. Pag partment cortant: l injury c		'4 □ Donation 5 □ Other (Specif	y)	Baltimo	re Cremat					more,		
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licer	Roma	rosbu	22. Name and Add							
	Pnysician /Medical Examiner	ner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a Due to (or a.	d the death. Do not ine. a consequence of): a consequence of):		ying, such as o	cardiac or r	espiratory a	rrest,		Approximate Interval Batw Onset and Di	reen
68760,	rificate be executed ng physician and as the burial-transit	Medical Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence of):						Col		
.O. Box	The law requires that the death certific ite has been signed by the attending p bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 □Ectopic pregnan 5 □ Other (specity)	cy			23d	. Date of deliv Month		ear .
Records, P.	w requires that been signed should be det	by	Part II. Other significant conditions c	ontributing to death t	out not resulting in the	underlying cause o	piven in Part I.			obacco use d		the cause of dea	
Reco	The law nate has be page 2 sh	Completed									4b. Were autoprior to codeath?	opsy findings avompletion of cau	vailable use of
Viitai	E E	Bec	25. Was case referred to medical examiner?				26. Place	of Death (C	Check only o			2.0	
_	S S	္	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpati	The state of the s	OIL OUN		sing Home	5 🗆 Resid	dence 6	Other (Speci	fy)	
Division of	ling F	on:	27. Manne of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry 28b. Time ly Yea <i>r)</i> Injur	W			d. Describe h	now injury oc	curred		
200	uttendii death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be		un. At hama farm]Yes 2□N		Lanation (f	Thromas and Asia		.10	
<u> </u>	l or A after Direction by	Certification:	4 ☐ Homicide determined	building, e	ury - At home, farm, c. (Specify)	street, lactory, office	•	201.	City or Tow	m, State)	umber or Hur	al Route Numbe	9 <i>r</i> ,
		Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis of and manner st	of my knowledge, de f examination and/or ated.	ath occurred at the investigation, in my	time, date and opinion, death	place, and	I due to the d at the time, d	cause(s) and date and pla	manner as s	stated. o the cause(s)	
	To th withir To th comp	Me	29b. Signature analytitle of certifier	1.01		29c. Licer	nse number			29d. Date sig	gned (Month,		
	4		· Wast	SU CO		DS	7181	9	4	201	7	4, 200	15
			30. Name and address of person who	completed cause of c	leath (Item 23a) (Typ	e, Print)	181 Mat	tthew	y Mal	tsa z	1401	-	
	Stat Registra	2.0	31. Date filed (Month, Day, Year)	32. R str	ar's Signature		***		·				

Rlease Type or Print in Black Indelibio ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Nicholas Raphael Falco III 2 Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 2:37 KM 4 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MARYLAND MEDICALS YSTON BALTIMORE Social Security Number BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. X 2 F Yrs. 25,1983 **Director** MARYLAND 213-17-9605 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo MARYLAND CHARLES LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 20646 603 CLARKS RUN ROAD U.S.A. Funeral death death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give △ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2XXVo Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE "natural", Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NETWORK ENGINEER HEWLETT PACKERD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental ant: If item 27 is marked c ည NICHOLAS R. FALCO, JR. PATRICIA YASMINE SIMONS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA PRUSS - MOTHER 603 CLARKS RUN RD., LA PLATA, MARYLAND20646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) METROPOLITIAN CREMATORY 7-30-05 ALEXANDRIA, VA M00479 21. Signature of Juneral Service Licensee 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as caldiac of respiratory arrest, 646 shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Blunt **Physician** trauma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): N Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2000 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Qay Year) 28b. Time of 28d. Describe how injury occurred Manner of Death Injury 1 Natural 241 12:20AM MOTOR death. investigation 3005 VeHILLE COLLISIVON 2 Accident after death Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide anticol established PECE LDUTE within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 Homes, MD Waunda AU4176 435 TILSTZ

Registrar DHMH 17 Rev 1/2001

State

Valaunda m

31. Date filed (Month Aday C

200th

32. Ragistrar's Signature

Greene Street BAZA MOND ADDO1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

/HomA

3 2005

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

				State of Maryl		artment of rtificate of		, 0	ene g. No) / /	·						
			1. Decedent's Name (First, Middle, La.	st)				2. Dete of Deeth	2.01	15	3. Time	or Depth				
	Physici		GEORGE LOUIS FIS	HER				JULY 27	Day 2005	Year	7 . 2	5 PM				
н	/Medio Examir		4a Fecility Name (If not institution, give				4b. City, Town, or		4c. County	of Death	,					
	LXUIIII		GARRETT COUNTY M	EMORIAL HOSP	ITAL		OAKLAND		GAR	RETT						
	Funeral		Social Security Number 6. S		yrs. last birthday)	If Under 1 Yea Months Day		8. Date of Birth	1		ice (State	e or Foreign				
ď.	Director		207-26-4581	Юм 2□ F 71	Yrs.	MOILIS Day	s Hours Min.	OCT. 12,	1933	Courin	" P	A				
	p ,	' [Usuel Residence of Decedent	100	. City, Town or Lo	ontion				10	d l==:	City Limite				
	anyle show	-	10a. Stete 10b. County							10		City Limits as 2 No				
	ha M	act c	PA ALLEGH	ENY PI	TTSBURGH	1		1.0		411		-A-110				
	with to	古	10e. Street end Number	DT		10f. Zip Code		10	g. Citizen of V	vnet Counti	yr					
	a 23	era	157 BRALLIER COU	12. Was Decedent Ever i	in II C 13 1	152		pocify Voc or No	USA	e - America	n Indian					
Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours efter death with tha Marylend Department of Health and Mental Hygiene. Important: If Item 27 is merked other than "naturel", or items 23a or 28e-f show any Injury or other traumatic event, the Medical Examiner must be notified at pince.	by Funeral Director	11. Maritel Stetus 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:		If Yes, specify Cu	Hispanic Origin? (Slban, Mexican, Puerlo Specify:	to Rican, etc.)		ck, White, e	tc.					
2-0	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ucation	16e. Deced	dent's Usuel Occ	upetion	rkina 16	6b. Kind of Bu	usiness/Indu	ıstry					
2	thin thin	ple	Elementery/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retii	e during most of wo	9								
2	ed wi	S	12		YAR	DMAN			CSX RA		7D					
u	tal tal H oth	Be	17. Father's Neme (First, Middle, Last)		D			me (First, Middle, Mi	aiden Sumam	-	.					
<u> </u>	should be and Mental merked of umatic eve	2	JOHN	FISHE	7		SARAI			BROWN						
a N	d 2 shoth and 7 is mutaum		19a. Informant's Neme/Relationship (1) LOUISE FISHER - 1			BRALLIEI		rel Route Number, PITTSBU								
	1 and Health em 27 other tr	-	20a. Method of Disposition		b. Place of Dispo	sition (Name of			Oc. Location -							
2	Peges nent of I int: If ite iry or o		1 N Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	cemetery, crem SIRMINGHA	natory or other p	-		ITTSBU	Ť						
Baltimore,	artme ortani Injur	-	21. Signaluge of Funeral Service Licen	<u> </u>		. Name and Add										
ñ	permit. Departmit. Importations any Infu		Effect MLD,					1E - OAKLA	P.O. BOX 243 - OAKLAND, MD 21550							
			23a. Pert1. Enter the diseese, or comp shock, or heart failure. List only	ilications that caused the done cause on each tine.	leath. Do not ent	er the mode of dy	ying, such as cardia	or respiratory arres	st,	; 1	Approxim Interval B Onset an	letween				
	Physician /Medical		Immediate Ceuse (Final								Ji iset air	o Deam				
К	Examiner		disease or condition resulting in death)	ease or condition a. METASTATIC PROSTATE CA YRS												
		ē		Due t	to (or es a conseq	juence of):				į						
	v requiras that tha death certificata be executed been signed by the attending physician and should be dateched for usa as the bunal-transit	edical Examiner	Sequentially list conditions	b												
oʻ	e exercian ar	EX	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							i						
68760,	ata b hysic the b	S	that initieted events resulting in death) Lest	Due to	o (or as a conseq	uence of):				1						
	entific ling p			d						1						
Bo	ath o	lan		V.												
o	the a	Physician/N	Part II. Other significant conditions of	ntributing to death but not	resulting in the ur	nderlying cause o	given in Part I.	23b. Did tob	acco use cor	ntribute to 1	he caus	e of death?				
Vital Records, P.O. Box	The law requiras that tha death censte has been signed by the attending page 2 should be dateched for usa	F	COPD					1 🗆 Yes	2□ No	3 ☐ Probe	ibly 4	⊉Unknown				
g G	sign d be	d b						24a. Was en	autonsv	24b. Wer	e autops	v findings				
ò	been shou	Completed by						performe		avai	lable prio	ir to				
Ä	has ge 2	E						40	05/2		eath?					
g	n: The ficete or, pa	ပိ	25. Was case referred to medical				00 81	1 ☐ Yes		10	Yes 2	⊔ No				
	Physician: r this certific aral director,	o Be	examiner?	Hospital:	2 ☐ ER/Outpetien	t 3□ DOA	thor:	ath <i>(Check only one)</i> Iome 5□ Residen		or (Canaifel						
ō	Physic rithis aral d	2	27. Menner of Death	28a. Date of Injury	28b. Time of			28d. Describe how								
o	Attending or deeth. •ctor: After by the fune	탏	Natural 5 ☐ Pending 2 ☐ Accident investigetion	(Month, Dey Year	r) Injury		onk? ⊒Yes 2⊒No									
Division of	5 tg tg ⊆	Certification:	3 ☐ Suicide 4 ☐ Homicide Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)													
	To the Hospital or A within 24 hours efter To the Funeral Direct completely filled in by	edicai	29a. Certifier (Check only one) 29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
	o the	N N	29b. Signature and title of certifier			29c. Licer	nse number	290	f. Date signed	d (Month, D	ay, Yeer,)				
	⊢ ≯ ⊢ ŏ		17/0h	nn		D	×227		71>8	YOU						
	18+VA	-	30. Neme end eddress of person who d	completed cause of deeth (Item 23a) (Type.	Print)	0 22	2	//	11 -0						
			THOMAS G. JOHNSON		311 N.		T. OAKLA	ND, MD 21	550							
	Sta	te	31. Dete filed (Month, Day, Year)	32. Registrer's Si	gneture	A										

ORIGINAL

DHMH 16 Rev 6/95

			1 - For State Registrar		State of	Marylar	nd / Depa <i>Cei</i>	artmen rtificate			and M	lental F	lygien Reg. N	200)5	253	0.3
	Dhariai		1. Decedent's Name (First,	Middle, Last)							2. Date of Month	Death Da	av	Year	3. Time of	Death
н	Physici /Medic		Ruth Rosalie	Frant	z							July		2005	1001	6:20	Αм
	Examin	er	4a. Facility Name (If not ins	_		ber)		-		Location of	of Death		4	c. County	of Death		
			Goodwill Men 5. Social Security Number	nonite 6. Se		Ann Unive	lo at hirthday		ntsv 1 Year	ille If Under	24 Hre	0.5-1(D'-11	Garr			
	Funeral Director		215–34–4650 Usual Residence of Deced	10	х]м 2 Х ГГ	. Age (in yrs.	. last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of (Month, Aug.	Bay Year	15	Mary	place (State on ntry) Iand	r Foreign
	land			County		10c. Ci	ity, Town or Lo	cation							1.	10d. Inside Ci	ity Limits
	Many f sh	ğ	MD Ga	rrett		Fri	.endsvi	11e								1 X Yes	2 🗆 No
	r 28a	Director	10e. Street and Number					10f. Zip	Code				10g. C	itizen of V	What Cou	ntry?	
	th wit	a	275 Maple	Stree	t			2	1531				US	SA			
	ems ems	Funeral	11. Marital Status		12. Was Deced		J.S. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Sp	ecify Yes or Rican, etc.)	No-		e - Americk, White,	can Indian,	
36	or It	by Fu	1 Never Married 2[1 ☐Yes If Yes, Give	2 🙀 No		1 ☐ Yes 2		Specify:	•			Specify	,		
Ö	72 hours after death with the Maryland neturel', or Items 23a or 28a-f show asal Examiner must be notified at		3X Widowed 4 □ Dir	cedent's Edu	Year or Da	tes:	16a Dagg	dont's Heur	1 000000	ation.			105		Wr	ite	
5	in 72	olete	(Specify only	highest grad	e completed)		(Give	dent's Usua kind of wor DO NOT us	rk done d	<i>lurina</i> mosi	t of work.	ing	160.1	Kind of Bu	usiness/in	dustry	
21215-0036	e filed within II Hygiene. other then "	Completed	Elementary/Secondary (0-12)	College (1-	40r 5+)	Н	omema]	ker					Own	Home	е	
	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "neturel", or Items 23a or 28a-f show event, the Madical Examiner must be nutitied at	Bec	17. Father's Name (First, A	fiddle, Last)						18. Mothe	r's Name	(First, Mide	de, Maide	n Sumam	7e)		
<u>laı</u>		ည	Benjamin Fr	anklin	Schroy	er						izabe					
Maryland	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Re	lationship (T)	rрө, Print)							al Route Nur			State, Zip	Code)	
	and fealth im 27 her tr		Dorothy L. F	rantz/	Daughte				alderstands and the second	Morg		wn, W	_	507			
Baltimore,	00		20a. Method of Disposition 1 X Burial 2 ☐ Crem			tate	Place of Dispo cemetery, crer	natory or of	ther place	1		Date	No.			own, State	
턡	글 본 분 글 .		'4 □Donation 5 □ O			Bl	coming	Rose	Ceme	etery	Jul	y 22,	2005	Fri	ends	ville,	MD
Ba	permi Depa Impo any ii		Dos		ume	w						man Fi			mes, 1536	P.A.	
			23a. Part 1. Enter the dise	ase, or comp	ications that ca	used the dea								ے کا	1550	Approximat	
	Physician		shock, or heart failure Immediate Cause (Final	e. List only o	ne cause on ea	ch line.	harry	f.	1		7 6 17	00				Onset and	
	/Medical		disease or condition resulting in death)	-	Due to	r as a consec	quence of):	- Inc	ure							4 We	uy
	Examiner		Cognostially list conditions		her	porte	nion)								ueas	3
-	ם ב	lner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury)	•]	Due 6	r as a consec	quence of):										
	ecute and -trans	Examlner	that initiated events resulting in death) Last	1	c. dia	r as a consec	type	1								year	5
8760,	icate be executed physician and s the burial-transit	Ical E	, ,		6/10/0	FALL	PM G.I	SAVE	600	x	Gil	1110				illal	K
687	The law requires that the death certificate be executed as has been signed by the attending physician and page 2 should be detached for use as the burial-transit	olbe		•	d	OIVIC (conge	5 /7 V L	-100		Tree t					year.	
Box (that the death certific ed by the attending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent gregn:	ant 4	3c. If yes, outc									23d. Dat	e of delive	erv	
	death e atte d for	Icla	in the past 12 months 1 ☐ Yes 2 🗷 No		4□Pregna	th 2∏Fete ntattime of o		Ectopic pro Other (spe					_	Moi			Year
P.0	at the by th tache	hys	9 Unknown		9□ Unknov	₩N		_									
	res tha igned be det	by	Part II. Other significant c	0	n e			. •	ause give	n in Part I.		23e. Di		_/		he cause of d	
ord	w require been si should b	ted	unstage re	nal o	iseare	<u>-ane</u>	mea					11	⊒Yes 2	2 X No	3 ☐ Prob	ably 4 □L	Jnknown
Records,	elaw hasb je 2 sh	Completed											topsy	F	prior to co	psy findings mpletion of c	available ause of
ᆵ												1 ☐ Ye	rformed 2 XN		death?	2□ No	
ΖË) Be	25. Was case referred to n examiner?		fospital:				Othe	-		(Check on	-		70.		
oţ	Phys or this oral di	. To	1 ☐ Yes 2 No 27. Manner of Dath		28a. Date of		ER/Outpatien 28b. Time of		8c. Injury	at C		me 5 □ Re 28d. Describ				y)	
<u>o</u>	ttending F death. ctor: After / the funer	atloi		Pending nvestigation	(Month	, Day Year)	Injury	М	Work	.? /es 2 🗆 !	Vo						
Division of Vital	ar degreeto	Certification;		Could not be determined	28e. Place o	of Injury - At h	nome, farm, str	eet, factory	, office			28f. Location	n (Street a Fown, Stat	nd Numb	er or Rura	il Route Num	ber,
ō	itel or irs afte rel Dire				1						-						
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifier 115 Co (Check only one)	ertifying Phy edicel Exemi	sician: To the t ner: On the ba: and manne	sis of examina	owledge, death ation and/or in	n occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, th occurr	and due to the due to	ne cause(s e, date an	s) and ma nd place, a	nner as si and due to	tated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of	certifier	-	/ \		29c	License	number						Day, Year)	
	r->=0		▶ Mass	arel	U K	un	28	In .	03	266	50			7/2	2/0	25	
	K		30. Name and address of	erson who co	ompleted cause	of death (Iter	m 23a) (Type,	Print)	0	JU 01	1 1			7/2 Wer			7 1-
_	1		Margare	+ KO	user,	MD.	1307	9 B	101	rett	141	NY.C	ar	Sar	nd	MD	9175
	Sta Registr		31. Date filed (Month, Day,	Year)	2005 N	gistrar's Sign	ature	el a	4			, ,					

			For State Registrar	State of Marylan	d / Depa		ealth and M	lental Hygi	9	25201
			Decedent's Name (First, Middle,	l ast)		1 1	704177	2. Date of Death		3. Time of Death
	Physici	an		·		telacla			B, 2005 Year	
	/Medi			IZABETH		1170-	l	Jury 19		11:33 A ^M
	Examir	ier	4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or	Location of Death		4c. County of Death	
				entist Hospital		Rockvil	le		Montgomer	V
	Funeral		5. Social Security Number	Sex 7. Age (In yrs. i	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		place (State or Foreign
	Director		209-32-8540	1□ M 2 ½ F 63	Yrs.	Worth's Days	Hours Win.	April 26	1942 Penns	Sylvania
	D .		Usual Residence of Decedent							
	nylar how		10a. State 10b. County		, Town or Lo	cation			1	10d. Inside City Limits
	Ma-f.s	Ş	Maryland Montgo	mery Den	rwood					1 ☐ Yes 2X No
	r 28	irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cour	ntry?
	3a o	0	17805 Park Mill	Drive		20855			United Sta	tes
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Examirer must be nutflied at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.	S. 13.		spanic Origin? (Spe	ecify Yes or No-	14. Race - Americ	
	Her Iter	15	1 ☐ Never Married 2 2 Marrie	Armed Forces?		Was Decedent of His If Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	Black, White,	
36	rs af		3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify: Wh	nite
21215-0036	72 hours after dea natural, or Items lical Examiter or	Completed by	15. Decedent's		160 Dogg	dont's Heuri Ossuna	tion		Oh Kind of Business de	4
5	n 72	let	(Specify only highest		(Give	dent's Usual Occupa kind of work done di DO NOT use retired)	uring most of work	ng '	6b. Kind of Business/In-	dustry
12	within iene. than "	Ē	Elementary/Secondary (0-12)	College (1-4or 5+)						-
2	be filed within 72 ho ital Hygiene. id other than "natu event, Ite Moulcal		17. Father's Name (First, Middle, La		Para	educator	10. 14-14-14-14-14-14		Special Edu	cation
Ē	be fi	Be	Richard O'Donnel	·			18. Mother's Name	100	alden Sumame)	
yla	should be ad Menta marked matic ev	2		Transaction and the second			Doris W	agner		
Maryland	0 6 00 5		19a. Informant's Name/Relationshi						City or Town, State, Zip	
	1 and 2 Health tem 27 I		Joseph Flach/ H					Derwood	, Maryland	20855
Baltimore,	iter oth		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of matory or other place	9)		0c. Location - City or To	own, State
Ĕ	permit. Pages Department of i Important: If ite any injury or o		1 ☐ Burial 2 X Cremation 3 1 ☐ Donation 5 ☐ Other (Spe	LI tellioval ilolli State		itan Crem.	July	22, A.	lexandria,	Vircinia
alt:	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service L	4		. Name and Address			eral Home	viiginiu
ä	Depar Impor any ir		John 117		10) East Dee			ithersburg,	MD 20877
			23a. Part Enter the disease, or c	omplications that caused the death						Approximate
Ь			23a. Part Enter the disease, or co	ly one cause on each line.	•	er tille illegge er eying	,, 000 00 00.0.00	a respiratory arro	Pi	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a MOMARY	nc (Micin	unis :	euni	UUN IMMY	r 4 myns
	/Medical Examiner		rooding in doutry	Due to (or as a consequ	ience of):		7)	eur Pringer	•
ы			Sequentially list conditions,	b						
	p #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	ience of):					
	nd nd trans	аш	Cause (Disease or injury that initiated events	c						
o,	te be executed ysician and ne burial-transit		resulting in death) Last	Due to (or as a consequ	ience of):					
760,	a × 6	cal		d						
68		ed								
Вох	death certifica attending ph of for use as the	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of delive	erv
ă	eath atte	cia	in the past 12 months?	1□Live birth 2□Fetal 4□Pregnant at time of de		Ectopic pregnancy Other (specify)			Month	Day Year
0	at the de by the a tached	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown						
<u>α</u>	th,		Part II. Other significant condition	s contributing to death but not resu	Iting in the u	nderlying cause give	n in Part I	23e. Did toba	acco use contribute to the	ne cause of death?
Records,	sign sign d be	1 by		• 5		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			2 □ No 3 □ Prob	
orc	w requir been si should	ompleted						1 103	2 2 10 0 1100	ably gas of known
ec	e law has b	ple						24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
<u>~</u>	The ate has page	Соп						perform	ed? death?	2□ No
Vital	sician: Th certificate rector, pag	a	25. Was case referred to medical				26. Place of Death			
>		.o B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 1	ER/Outpatien	t 3 DOA Other	r: 4 🗆 Nursing Hor	ne 5□ Residen	ice 6 Other (Specify	v)
of		i.	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury	at :	28d. Describe how		,
on	ding F th. : After tuner	tlo	Natural 5 Pending 2 Accident investiga	(Month, Day Year)	Injury	Work′ M 1 □ Y	? 'es 2∐No			
S	Attending r death. sctor: After by the fune	fica	3 Suicide 6 Could no	be as Blace of Isium. At he	me, farm, str	eet factory office	i i	28f. Location (Stre	eet and Number or Rura	I Route Number
Division	Dirte	ertification;	4 ☐ Homicide determin	building, etc. (Specify		,,,		City or Town,		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	O	29a. Certifier 1 Certifying	Physician: To the best of my know	viedne dans	Localized at the time	a date and alass	and due to the a-	sca(a) and man-	ented
	Hos 24 ho Fun stely	edical	(Check only 2 Medical Ex	aminer: On the basis of examinat and manner stated.	ion and/or in	estigation, in my opi	inion, death occurr	and due to the cat ed at the time, dat	e and place, and due to	ated. the cause(s)
	thin 2 the the mplel	Mec	29b. Signature and title of certifier	and manner stated.		29c. License	number	20	Date signed (Month)	Day Vees
	To Too		NI IAI			250. LICHISH	1.3111001	290	d. Date signed (Month, I	Day, real)
,	12		WHIMANK	- MID.		53	177		44 14,9	005
			30. Name and address of person wh	o completed cause of death (Item	23а) (Туге.	Print) John	N M. WAL	YMARK, M	2626	
			7701 Mac	ULAL CONTOR	- 1X	noch	ille, M.	J. 00	2010	
	Sta		31. Date filed (Month, Day, Year)	30 Registrar's Signat	ure Ann	00 -	1			
	Registr	ar	JUL 4 0 7	UUD Hallen K	Jan.	150 N				

GEORGE FORMAN, 05-4763				ible Ink. Ensure	-	_	
05 1705	1 - State Unpend Item	23a,27,28a-f	per me G8	46.8-10-05 tas	Rea	. Non O O	
Physician /Medical	1. Decedent's Name (First, Middle, Las				2. Date of Death Month	2005 Day Year 4, 2005	2505 1944 PM
Examiner	4a. Facility Name (If not institution, give UNION MEMORIAL HO		E	City, Town, or Location of Deat	h	4c. County of Death	
Funeral Director	5. Social Security Number 6. S 218-02-5193 1. Usual Residence of Decedent	du one		Under 1 Year If Under 24 Hrs nths Days Hours Min.	8. Date of Birth (Month, Day, Y	9. Bint Co.	nplace (State or Foreign untry)
death with the Maryland ms 23a or 28a-1 ehow must be notified at never a present of the contract or never an or or or or or or or or or or or or or	10a. State 10b. County	RICK W	City, Town or Locatio	ille			10d. Inside City Limits
th with the Mar 23a or 28a-f et at be notified	10e. Street and Number 8766 BEAC	ON CIRCO		7. Zip Code 21793		Citizen of What Co	untry?
5 £ 5	11. Marital Status Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Decedent of Hispanic Origin? (S., specify Cuban, Mexican, Puer es 20 No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify: Bl	e, etc.
15-0 72 ho 72 ho 172 ho 10 total	15. Decedent's Ed (Specify only highest gra	lucation de <i>completed)</i>	(Give kind	Usual Occupation of work done during most of wo	rking 16	b. Kind of Business/I	ndustry
21215-00 ed within 72 hou ygiene "netura serthan "netura it, tre Medical Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 2 Yr3.		OT use retired) UET SUPERV	ISOR H	OUDAY	INN
Baltimore, Maryland 21215-0036 sernit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiens. Properties I flem 27 is marked other than "netural", or my Injury or other traumatic event, the Medical Exami Dice. To Be Completed by F	17. Father's Name (First, Middle, Last) 6 EORGE F	DREMAN Z		RUTH	me (First, Middle, Ma. STANTON	/	
re, Maryla s 1 and 2 should theath and Men treum 27 is marke other traumatic	19a. Informant's Name/Relationship (19a. RUTH FOREMAN	• • • • • • • • • • • • • • • • • • • •	19b. Mailing Ad	dress (Street and Number or Ri BEACON CIR	ural Route Number, C	ity or Town, State, Z XFRSV10	(ip Code) 2179; LE MD.
other	20a. Method of Disposition	206	. Place of Disposition	(Name of	Date 20	c. Location - City or	Town, State
Limor Pages Iment of tant: If It	1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Political Holli State	AIRVIEW	com. Jul	y 20,05 F	REDERIC	ie mo
Baltimore, Mc permit. Pages 1 and 2 Department of Health a Important: if them 27 is eny Injury or other trau	21. Signature of Funeral Service Licen	ellis	22. Nar <i>GA</i> /	me and Address of Facility RY L ROCCIN L ROCCIN R R R R R R R R R R R R R R R R R R R	S FUNCRA	I HOME	21701
	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de					Approximate Interval Between
Physician /Medical	Immediate Cause (Final disease or condition resulting in death)	a. Anaphylacto		on			Onset and Death
Examiner	1	Due to (or as a cons	equence of);				
sit sit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a cons	equence of):				
60, be executed sician and burial-transit	that initiated events resulting in death) Last	c. Due to (or as a cons	equence of):				
8760, ate be ex hysician the burial	•	d					
of Vital Records, P.O. Box 687(Physician: The law requires that the death certificate by this certificate has been signed by the attending physical director, page 2 should be detached for use as the b. To Be Completed by Physician/Medica.;	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3 Ecto	pic pregnancy er (specify)		23d. Date of deliment	very Day Year
Division of Vital Records, P.O. for Attending Physician: The law requires that the darker death. Director: After this certificate has been signed by the fin by the funeral director, page 2 should be detached in by the funeral director, page 2 should be detached ertification; To Be Completed by Physician and the properties of the prope	Part II. Other significant conditions o	ontributing to death but not r	resulting in the underly	ring cause given in Part I.		cco use contribute to	the cause of death?
al Record The law requir cate has been si page 2 should Completed					24a. Was an autopsy performed	24b. Were autoprior to death?	topsy findings available ompletion of cause of
of Vital Physician: The this certificate this director, page 70 Be Co	25. Was case referred to medical examiner?	11			ath (Check only one)	77.00	
Of \Physical Physical directions of the contraction	Yes 2 No 27. Manner of Death		ER/Outpatient 3 28b. Time of Un Injury	DOA Other: 4 Nursing H	lome 5 Residenc		
Division of standing P rs atter death rs atter death rs all Director: After led in by the funera Certification;	1 □Natural 5 □ Pending 2 ▼ Accident investigation	1 12 03	Injury N	Work? 1 ☐ Yes 2 🛣 No	during su	rgery	medication
Division attend after death i Director: vi bi by the fidin by the fidentification certification.	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe			28f. Location (Stree City or Town, S	et and Number or Ru State) Union	Memorial Maryland
Division To the Hospital or Attending within 24 hours after death to the Funeral Director: After completely filled in by the fune Medical Certification	(Check only 2 Medical Exan	Union Memory ysician: To the best of my k niner: On the basis of exami	nowledge, death occ	tal urred at the time, date and place lation, in my opinion, death occu	and due to the caus	e(s) and manner as	stated.
To the Hospital within 24 hours a within 24 hours a completely filled	29b. Signature and title of certifier	and manner stated.	22 or 11193ttg	29c. License number		Date signed (Month	

State Registrar 31. Date filed (Month,

30. Name-end address of person who completed cause of death (Item 23a) (Type, Print)

AKULLAND, 21201 32 Raistrar's Signature

OCME

JULY 15, 2005

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 15, 2005 **Physician** 9:34 Marguerite Audrey Fountain /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Rockville Montgomery Casey House 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 5. Social Security Number **Funeral** Days Hours Min. Months 1 M 2 TF 514-36-0479 90 Director Sept 30, 1914 Kansas Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and terms 23a or 28a-f show ant: If item 27 is marked other than "natural" or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County t: If item 27 is marked other than "natural", or items 23a or 28a-f show y or other traumatic event, the Medical Ever, there is net institute to cititized at 1 X Yes 2 □ No MD Silver Spring Montgomery Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3700 International Drive 20906 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 2**X** No 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White þ If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) Librarian Library 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harold Warner Olga Wendling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 a
Department of Health ar
Important: If item 27 Is
any injury or other trau 17308 Twin Ridge Ct. Silver Spring MD 20905 Glen Fountain / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) August1,2005Arlington Kansas Arlington Cemetery 22. Name and Address of Facility Joseph Gawler's Sons 21. Signature of Funeral Service Licensee 5130 Wisconsin Ave. NW Washington DC 20016 Muna 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Advanced Myelodysplastic Syndrome /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transit certificate be executed Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day for 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown þ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown icate has been sig r, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ₹ No Hospital or Attanding Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 MOther (Specify) Hospice 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes Z∑ No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 5 Pending investigation 1XXVatural 1 ☐ Yes 2 ☐ No death. Accident after death 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the I To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title to certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Harrison -6001 Muncaster Mill Rd. Rockville, MD 20855 3 Registrar's Signature 31. Date filed (Month, Day, Year) State 19 2005 JUL Registrar

Amend item#25,27,28a-f, perME,G846,8/11/05 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. () 2. Date of Death 1. Decedent's Name (First, Middle, Last) July Day **Physician** Aaron John Fuller 10, 2005 8:05a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town or Location of Death 4c. County of Death Examiner University Specialty Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Dave | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 153 M 2 □ F Yrs Director 25 Jan. 1980 Wisconsin 392-94-5482 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at MD Anne Arundel 1 ☐ Yes 2 XNo Director Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ò 806 Barrett Avenue 21012 or items 23a USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 7 Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) General Laborer Construction 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John H. Fuller Paula R. Deyo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Dep. riment of Health at Important: If Item 27 is any Injury or other trau John Hasty Fuller/Father 806 Barrett Avenue Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July Date 15, 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State 2005 Metro Crematory Baltimore, MD ^¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. 21. Signature of Euneral Service Licensee Severna Park Funeral Home Severna Park, MD 21146 ULI 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respir tory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) M Pnysician OCAND, e /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine CERTIFICATION APPROVED BY MEDICAL EXAMINER certificate be executed use as the burial-transit Due to (or as a consequence of) attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ŏ Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown þ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, þ 2 No 3 Probably 4 Unknown Completed After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Yes or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one, Other: XXYes 2 1 Inpatient 2 ER/Outpatient 3□ DOA ■ Sursing Home 5 Residence 6 Other (Specify) DWision of 28d. Describe how injury occurred **Driver in** 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification; 5 Pending Vatural Accident 1 ☐ Yes 2 death. 11/25/2003 1:30 A^M investigation truck/fixed object impacts Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Bural Route Number, City or Town, State) 1-695 at ramp filled in by 4 | Homicide roadway to Rt.2, Glen Burnie, MD 24 hours a Hospital 29a. Certifier 1 Gertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 Fo the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) homas tolkemer Pasadena MD 32. Resistrar's Signature State

Registrar

JUL 1 5 2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) July **Physician** 20°0°5 Robert Waldrop Floyd 6:45 pM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Chesapeake Hospice House Linthicum Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 X M 2 □ F Director 72 13, 1932 Washington, 577-40-3453 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits in than "natural", or Iteme 23s or 28s-f show the Medical Examilier; just be notified at 1 ☐ Yes 2 → No Arnold Director MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 362 Oak Drive 21012 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Walter Reed Army Elementary/Secondary (0-12) College (1-4or 5+) 5+ other than Project Director Medical Center 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Ie marked oth any injury or other traumatic eventone. Claude William Floyd Frieda Louise Averv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline H. Floyd/Wife 362 Oak Drive, Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Jul. 14, 2005 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Baltimore, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home
495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Glioblastoma multiforme Immediate Cause (Final **Physician** disease or condition resulting in death) 4 Cars /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the death certificate be executed use as the burial-transit that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. the 9 Unknown 9 Unknown signed by the The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 20 No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24a. Was an autopsy performer 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 certificate 1 ☐ Yes or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Tes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Other (Special P Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred completely filled in by the funeral Certification: After 1 Natural 2 Accident 5 Pending investigation 1 TYes 2 □ No death. Director 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Keenine Weeny, Mis 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Bestagte Road #300. Werner. lanine 32. Rastrar's Signature 31. Date filed (Month, Day, Year) State **JUL 15** Registrar

		1	For State Registrar		State	of Maryland		rtment of Hetificate of L		Mental Hygi Rei	ene 2005	25309
			Decedent's Name	(First, Middle, La	st)					2. Date of Death	1	3. Time of Death
	Physicia		Barbara	Mara Fa	rrell					Month July	Day Year	Q. 7.5 AM
	/Medic Examin		4a. Facility Name (If r			ım ber)		4b. City, Town, or	Location of Deat		4c. County of Dea	
			2004 Har	bor Gate	es Dr.	#11 8		Annapoli	is		Anne Ar	undel
	Funeral		5. Social Security Nur	nber 6.5	ex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9 Ri	irthplace (State or Foreign Country)
ш	Director		578-38 - 917	1	□ M 2000F	88	Yrs.			May 18,		ngland
	pur *	- }	Usual Residence of E	Decedent 10b. County		10c. City.	, Town or Lo	cation				10d. Inside City Limits
	sho	5	Maryland	Anne An	cundel		apolis					1 Yes 2 No
	the N	Director	10e. Street and Numb				aporti	10f. Zip Code		10	g. Citizen of What C	Country?
	with				During	JL110		21/0	1			
	leath ns 23	Funerai	2004 Harb	or Gates	12. Was De	cedent Ever in U.S	S. 13. V	2140 Vas Decedent of His Yes, specify Cubar			nited Sta 14. Race - Am	nerican Indian,
10	fter o	Fun	1 Never Married	d 2 Married	Armed F	2 ₩ No		Yes, specify Cubar		to Rican, etc.)	Black, Wh	ite, etc.
93	hours after death with the Maryland tural; or Items 23a or 28e-f show al Eranii at instat be tredified at	by	3 ₹Widowed 4	Divorced	If Yes, G Year or	ive Dates:		LIYes 2LINO	Specify:		Specify: W	hite
2-0	72 In an	Completed	(Specifi	15. Decedent's E	ducation ade completed)	16a. Deced	lent's Usual Occupa kind of work done d DO NOT use retired;	ation Juring most of wo	rking 1	6b. Kind of Busines:	s/Industry
21	within iene. than "	mpi	Elementary/Second			(1-4or 5+)						
2	illed will Hygier the other the		12 17. Father's Name (F	inst Middle Last	1		Cafet	eria Mana		me (First, Middle, M	schools	
and	o d ta	Be								•	arden cumame,	
Ĕ	should ind Men s marke umatic	ဥ	(Unknown 19a. Informant's Nan				19h Mailir	n Address (Street a	Hilda B		City or Town, State,	Zin Code)
Maryland 21215-0036	12 s h ar 7 ls trau		Linda Fel		•			•		polis, MD	-	
ē,	permit. Pages 1 and 2 should Department of Health and Mer Importent: If item 27 Is marke any injury or other traumatic once.		20a. Method of Dispo	sition		20b. Pl		sition (Name of natory or other place			Oc. Location - City o	r Town, State
Baltimore,	ages ant of t: If it		1 □ Burial 2 🛅 `4 □ Donation 5			State	_		ı	15 2005	Baltimo	me MD
	permit. Pag Department Importent: I any injury o		21. Signature of Fun-			Dai		Cremator Name and Addres	s of Facility To	hn M Tav	lor Funer	al Home, Inc.
Ba	permi Depa Impo any ir		1 1 9	with	Rom	mid					Annapolis	
			23a. Part1. Enter the	disease, or com	plications that	caused the death	. Do not ent	er the mode of dying	g, such as cardia	c or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (F	failure. List only inal	one cause on	dad n	C-01	vdin vo	1000/9	n deat	6	Onset and Death
1	/Medical		disease or condition resulting in death)	-	a. Due to	o (or as a consequ	ence of):	1910	1300			1 mino.
	Examiner				ATH	eroscla	not.	ic Card	10 vase	vland.	istace	10 years
١.		ner	Sequentially list condition any, leading to immicause. Enter Underlicause (Disease or in	ditions, nediate	Due to	o (or as a consequ	ence of):					
	cuted nd ransi	Examine	that initiated events	_	c							
0,	e exe ian a urial-1		resulting in death) La	ist	Due to	o (or as a consequ	ence of):					
8760,	The law requires that the death certificate be executed tae been signed by the attending physician and age 2 should be detached for use as the burial-transit	dical			d							
9	death certific attending pl	Φ :	IF FEMALE:		770 Huga a	utoomo of prognat						
Вох	ath cattend	ian	23b. Was decedent plant the past 12 g	ponths?	1 🗀 Live	utcome of pregnar birth 2 Fetal	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
o.	at the de by the a stached i	Physician/M	1 ☐ Yes 2 🕅 9 ☐ Unknown	No	9□ Unk	gnant at time of de nown	aun b	Jourer (specify)				
<u>α</u>	that the by detact		Part II. Other signific	ant conditions	contributing to	death but not resu	Iting in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?
Records,	sign sign d be	d by								1 ☐ Yes	s 2010 3□F	Probably 4 Unknown
Ö	w require been sign	Completed								24a. Was an	24b. Were a	autopsy findings available
Re	he lav	dmo								autopsy	prior to death?	completion of cause of
Vital		Ö	25. Was case referre	ed to medical					26 Place of De	ath (Check only one	No 1□Ye	es 2 No
5		o B	examiner?		Hospital:	Inpatient 2 E	ER/Outpatier	t 3 DOA Othe	ar ^a	lome 5 Resider		vecify)
of	a the	n:T	27. Manner of Death		28a. Dat	e of Injury onth, Day Year)	28b. Time o			28d. Describe how		
<u>io</u>	# - 4 =	atio	1 Natural 2 Naccident	5 Pending investigation		intin, Day 1 ear)	rijury		Yes 2 □ No			
Division	Atte	tific	3 Suicide 4 Homicide	6 Could not I	288. Pla	ce of Injury - At ho ding, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Str. City or Town,		Rural Route Number,
Ö	tal or rs after al Din	Certification:					,					
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edicai	29a. Certifier (Check only	Certifying P	hysician: To t miner: On the	he best of my know basis of examinat	wledge, deat	occurred at the time	ne, date and plac pinion, death occ	e, and due to the car urred at the time, da	use(s) and manner a te and place, and du	as stated. Le to the cause(s)
	the Prin 24 the Front Properties	Medi	one)		and ma	inner stated.		29c. License			d. Date signed (Mor	
	To To	2	29b. Signature and t	itle of certifier		mn		29C. Elcerise	117790	-71	nd. Date signed (Mo)	lii, Day, Tear)
•			/	200	Vy 1	4111	\ -	NO	10217		1/17/	2005
			30 Name and addre	ss of person who	completed ca	use of death (Item	23a) (Type,	POF	-TOA) /	SLVD.	(POFTI	on) 710001114
	Sta	ate	31. Date filed (Month	h, Day, Year)	32.	Regilirar's Signat	ture	Co.	- 0 / 0 / -			7 3.4.117
	Regist			JUL 14	2005	X Bahar	K	Angell .				

		1 - For State Registrer	State o	f Marylar	•		of Health a of Death			giene Reg. No. 2	105	25210
Physici	an	Decedent's Name (First, Middle,							2. Date of Dea	ath Day	Year	5-Time of beath U
/Medic	cal	Hele 4a. Facility Name (If not institution,	n Elizab		ham	4h City Tow	vn, or Location	of Dooth	July	2 7, 2 4c. Count	OUS Death	07,40 AM
Examin	ner	101 Academy La		incer)			sapeake			Ced		
Funeral			S. Sex	7. Age (In yrs.	last birthday)	If Under 1 Y	ear If Under	24 Hrs.	8. Date of Birt (Month, Da	h		place (State or Foreign
Director		211-20-6561	1□M 201F	77	Yrs.	Months Da	ays Hours	Min.	DEC 14	, 1927	Penn	sylvania
and *		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					1	10d. Inside City Limits
Maryll f sho	ō	Maryland Cecil		C	hesapea	ake Cit	v					1 ☐ Yes 2 🏋 No
r 28a	Director	10e. Street and Number				10f. Zip Co				10g. Citizen of	What Cour	ntry?
th with	a D	101 Academy La	ne			219	915			Unite	ed Sta	ates
ems er m	Funeral	11. Marital Status	Armed Fo	edent Ever in U orces?	I.S. 13.	Was Decedent f Yes, specify	of Hispanic Or Cuban, Mexical	igin? (Spe n, Puerto l	cify Yes or No Rican, etc.)	- 14. Ra Bla	ce - Americ	
s afte	by Fu	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	d 1 □ Yes If Yes, Gi Year or D	ve		1□Yes 2🛚	No Specify:	:		Speci	^{fy:} Whi	+0
ture!	edt	15. Decedent's		ales.		dent's Usual O				16b. Kind of E		
hin 72 en "na	plet	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5+)	(Give	kind of work d DO NOT use re	lone during mos etired)	st of worki	ng			
ed with	Completed		4		Tea	acher				Educa		
be file	Be	17. Father's Name (First, Middle, La								Maiden Suma	me)	
noutd d Mer narke netic	P	Edward F. Yarn			19b Mailir	a Address (St	treet and Numb	-	eth Pal		State 7in	Codel
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28a-f show any injury or other treumetic event, I'm Medical Evaluation must be notified at once.		Russell S. Gra		and		-						and 21915
s 1 an f Heal item 3	1.3	20a. Method of Disposition		20b. I	Place of Dispo	sition (Name o	of !	С	ate	20c. Location		
Page: ient o nt: If ry or		1 X Burial 2 □ Cremation 3 1 4 □ Donation 5 □ Other (Spe		State	-	Cemeter	. 1	Augus 2005		Media.	Penns	sylvania
permit. Departminitumborte any infu		21. Signature of Funeral Service Li	censee	•	H	Name and A	ddress of Facili					
82589		1 Daniel.	S. He	elzz	10	33 W. S	tocktor	Str	eet, El	kton, N	dary1	and 21921
Physician /Medical Examiner		23a. Part1. Enter the disease, or c shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	omplications that only one cause on a Due to	each line.		20	f dying, such as			rrest,		Approximate Interval Between Onset and Death Immediate
be executed ician and burial-transit	dical Examiner	Sequentially list conditions, if any learns to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consection of the cons							7	years
To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 Live	itcome of pregn birth 2 ☐ Feta nant at time of d nown	al death 3	Ectopic pregr Other (specif	,				ate of deliver	ery Day Year
ss tha gned I		Part II. Other significant condition	1 . 1		/ -		· / /	,		1/		he cause of death?
w require been sig should t	ted	Congestive Hear	1 tailure	2 , Zn su	lin Hep	endent	Viabel	es	1 🗆 `	Yes 2 No	3 Prot	oably 4 □Unknown
n: The law r ficate has be or, page 2 sh	e Completed by	25. Was case referred to medical					OC Place	o of Double	24a. Was autor perfo	osy rmed? 2 /X No	Were auto prior to co death? 1 \(\sum \text{Yes} \)	psy findings available impletion of cause of
ysicia s cert direct	0 0	examiner? 1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DOA	Other	ursing Ho		dence 6 🗀 Ot	her (Specif	(y)
anding Ph sath. or: After th he funeral	ertification; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	ation	nth, Day Year)	28b. Time o Injury	М	Injury at Work?		28d. Describe	how injury occu	rred	
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	O	3 Suicide 6 Could no determin	ned 289. Place	e of Injury - At h					City or To	vn, State)		al Route Number,
24 hc 24 hc 3 Fun etely f	edical		Physicien: To th xeminer: On the l and mar									
To the To the To the Complex c	Me	29b. Signature and title of curtifier				29c. L	icense number			29d. Date sign	ed (Month,	Day, Year)
		M Farker	MO			DI	5314	-		July :	27,20	05
.1		30. Name and address of person w	no completed cau	se of death (Ite	т 23а) (Туре,	Print)	4					
. 4		31. Date filed (Month, Day, Year)	7 Ur	ا محراً ا	tospita	EK	10n,	7)				
Sta Regist	ate trar	AUG 0 3	2005	Erles.	B A	2042						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

400	JO		1 - For State Registrar	State of M	arylan				ealth a Death	and Me	ental Hy	giene Reg. No	2005	259	211
3	Physici /Medic		1. Decedent's Name (First, Middle, Last Christopher	D.	Good	done					2. Date of De Month JULY	Day	2005 Year	3: Time b	Death I A ^M
	Examin		4a. Facility Name (If not institution, give LAUREL REGIONAL H)	2		Town, or UREL	Location o	f Death			County of Dea	GEORGES	
χ.	Funeral Director		102 32 3230	X 7. A	ge (In yrs. 43	last birthday) Yrs.	If Unde Months		If Under 2 Hours	Min.	8. Date of Bir (Month, Da 09-29-	th 1961	9. Bi	rthplace (State ountry) La, PA	or Foreign
	Maryland -f ehow	tor	Usual Residence of Decedent 10a. State 10b. County			y, Town or Lo	cation							10d. Inside C	ity Limits
	with the	Director	PA Bucks 10e. Street and Number		Uak	1014	10f. Zip	Code 053				-	izen of What C	country?	
920	d within 72 hours after death with the Maryland liene. r then "natural", or Itema 23a or 28a-1 ehow the Medical Examble mottled at	by Funeral	4731 Iroquios Aven 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 QDivorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	?		Was Dece f Yes, spe	dent of Hi cify Cubai	spanic Origin, Mexican	gin? (Spec , Puerto F	cify Yes or No Rican, etc.)		14. Race - Am Black, Whi		e
Baltimore, Maryland 21215-0036	within ene. then "	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12th		5+)	16a. Deced (Give life. L	kind of wo	rk done a se retired,	luring most)	t of workin	g		ind of Business	s/Industry	
land 2	be filed htat Hyg od othe event,	To Be Co	17. Father's Name (First, Middle, Last) John Goodone			July			18. Mothe		(First, Middle.	, Maiden	Sumame)		
, Mary	ges 1 and 2 should t of Health and Men if Item 27 is marke or other traumatic		19a. Informant's Name/Relationship (7) Jeff Linkchorst/Br		-Law						Route Numb		or Town, State, 053	Zip Code)	
imore	Pages 1. ment of He ent: if iten ury or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		, 0	Place of Dispo emetery, cren Lady (natory or o	ther place			-2005		shorne,		
Balt	permit. Page Department of Importent: If any injury or		21. Signature of Funeral Service Licens	hall	2	74	474 L	ando	ver R	d La	ndover	, mD	neral H 20785	lome	
	Physician /Medical Examiner		23a. Part1. Enter the disease for comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)		evo	sclere							isuse	Approximal Interval Bel Onset and	tween
8760,	ate be executed obysicion and the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Due to (or as d.											
O. Box 6	The law requires that the death centificate be executed tie has been signed by the attending physicien and hage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant : 9 ☐ Unknown	2 Feta	Ideath 3□	Ectopic p						23d. Date of de Month	,	Year
ords, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death	but not res	ulting in the ur	nderlying o	ause give	en in Part I.		23e. Did t		_	to the cause of corobably 4 🗀	
al Reco		Completed		**							24a. Was auto perfo 1X Yes		prior to de 1/1?	utopsy findings completion of c s 2 \(\text{No} \)	available cause of
Division of Vital Records,	ding Physici n. After this cer funeral direc	ation: To Be	25. Was case referred to medical examiner? 1 Xyes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpat 28a. Date of Inj (Month, D		ER/Outpatien 28b. Time of Injury		28c. Injury Work	or: 4 □ Nu	rsing Hom	Check only one 5 Resi	dence	6 ⊡Other (Spery occurred	ecify)	
Divis	i Diagram	Certification:	3 Suicide 6 Could not be 4 Homicide determined		tc. (Specif	y) 					City or To	wn, State)	Rural Route Num	nber,
	the Hospital hin 24 hours a the Funerel npletely filled	edicai	29a Certifier 1 Certifying Phy (Check only 2 Medical Exami one)	ner: On the basis and manner s	of examina	wladge death	vestigation	at the time, in my or	ie, data ark pinion, deat	d place, a th occurre	nd due to the d at the time,	date and	and manner to diplace, and du	is stated. e to the cause(s	s)
	To the To the comple	Σ	29b. Signature and title of certifier Tabulle	108 A	R.			c. License OCI				JULY	te signed (Mon		
C			30. Name and address of person who con TABIU U.S. 31. Date filed (Month, Day, Year)	74 A	4	111 1	and the same of	STRE	ET, B	ALTIN	IORE, M	IARYI	AND, 2	1201	
	Sta Registi		JUL 1 8 2005	Cre JES	trar's Sir na										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JULY 29, **Physician** RONALD HOWARD GASKILL 2005 2:58 ΑM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GARRETT GARRETT COUNTY MEMORIAL HOSPITAL OAKLAND 8. Date of Birth (Month, Day, Yea DEC. 3, 1 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)
 MARYLAND 5. Social Security Number **Funeral** 1**∑**M 2□F 218-30-7173 71 1933 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 27 En marked other than "natural", or items 23a or 28a-f show translet event, the Medical Examinat must be notified at 1 Tyyes 2 □ No Directo MD GARRETT MT. LAKE PARK the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than """ any njury or other traumer: 1101 ALEXANDER LANE 21550 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MAIL CARRIER US POSTAL SERVICE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM HOWARD GASKILL DOROTHY MALLONEE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DORIS GASKILL - WIFE 1101 ALEXANDER LANE MT. LAKE PARK, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State OAKLAND CEMETERY 8/1/05 OAKLAND, MARYLAND ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Septice Lice 22. Name and Address of Facility M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 23a. Part1. Enter the disease, or com shock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death one cause on each line Immediate Cause (Final **Physician** E collapse disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only on Hospital: Other: 2 ۵ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Dale of Injury (Month, Day Year) 27. Manner of Death 1) Natural 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification; After 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) within 24 hours aft To the Funeral Di completely filled in Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1)26650 0

State Registra

30. Name and address o

Day, Year)

9

Margaret

31. Date filed (Month,

P.O. Box 68760

Division of Vital Records.

Kaiser, M.D 13079 Garrett Hwy Oakland MD 21550

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

		•	1- For State of Mary	/land / Depa		f Health a	and Mental Hy	_	05 25313
			Decedent's Name (First, Middle, Last)				2. Date of D Month		3. Time of Death
	Physicia /Medic		MARCELLA CLARE GILLETLY				JÜLŸ	24, 2005	6:40 PM
	Examin	_	4a. Facility Name (If not institution, give street and number)			n, or Location o	f Death	4c. County	
			OAKLAND NURSING & REHAB		OAKLA If Under 1 Ye		A Hre D D 4 D	GARR	
	Funeral Director		300-12-1446 ¹□м 2\overline{\text{M}} \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	n yrs. last birthday) Yrs.	Months Da		Min. 8. Date of B	26, 1919	9. Birthplace (State or Foreign Country) OHIO
	and	}	Usual Residence of Decedent 10a. State 10b. County 10	Oc. City, Town or Lo	cation				10d. Inside City Limits
	Manyi f sho	ō	MD GARRETT	OAKLAN	ND				1 X Yes 2 No
	r 28a	Director	10e. Street and Number		10f. Zip Cod	de		10g. Citizen of W	Vhat Country?
	th wit	alD	500 GLADE SQUARE APT. # 3	0	2	1550		USA	
	r dea	Funeral	11. Marital Status 12. Was Decedent Eve Armed Forces?	r in U.S. 13. V	Was Decedent	ol Hispanic Orig Cuban, Mexican	gin? (Specify Yes or N , Puerto Rican, etc.)	o- 14. Race Blac	e - American Indian, ck, White, etc.
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes. 2 ☒ No If Yes, Give Year or Dates:			No Specity:		Specify	WHITE
8	P hour	edt	15. Decedent's Education	16a. Decec	dent's Usual Oc	cupation		16b, Kind of Bu	Jsiness/Industry
215	within 72 hours after death with the Maryland ene. then "naturel; or items 23e or 28e-f show the Madical Exame actinist be notified at	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work do DO NOT use re	one during most stired)	of working		
7	ed wit	Son	12	SECRE	ETARY	·		1	CTURING
Maryland 21215-0036	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examt are must be multipled at once.	To Be	17. Father's Name (First, Middle, Last) CLARENCE OTT				r's Name <i>(First, Middl</i> LICE		ue) UEKEDE
ary	and N		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Str	reet and Numbe	r or Rural Route Num	ber, City or Town,	State, Zip Code)
	and sealth m 27		JUDY DEVLIN - DAUGHTER			ILL LAN		D, MD 215	
0	ges 1 If of H If ite or oti		1 ☐ Burial 2 X Cremation 3 ☐ Removal from State	20b. Place of Dispo- cemetery, cren	natory or other	place)	Date		City or Town, State
Baltimore,	it. Pa rtmen rtant: njury		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeval Segrice Licensee	OMEGA CR		Y ddress ol Facilit	7/26/05		TOWN, WV
Ba	Dep Impo		111 - 21111				HOME - OAK	. BOX 243 LAND, MD	
	Priysician /Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events c.	43		dying, such as		arrest,	Approximate Interval Between Onset and Death Stur
.O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	pregnancy]Ectopic pregna] Other <i>(specif</i>)			23d. Dat Mor	te of delivery nnth Day Year
ds, P.	uires that i signed b ld be deta	d by PI	Part II. Other significant conditions contributing to death but re	not resulting in the un	nderlying cause	e given in Part I.		2	nbute to the cause of death? 3 Probably 4 Unknown
Vital Records,	The law req te has beer age 2 shou	omplete	end stage heual anemie	a, Chn	mic o	bstrep	24a. Wa aut per 1 □ Yes	opsy formed?	Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
ita	ian: intifica ctor. p	BeC	35. Was case referred to medical examiner?			26. Place	of Death (Check only		
of <	Physician: r this certific ral director,	2	1 Yes No Hospital: 1 Inpatient	2 ER/Outpatien			rsing Home 5 ☐ Re		
o u	ing P	lon:	27. Manner of Death Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury		Injury at Work?		how injury occurr	red
Division	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	2	- At home, larm, str Specify)		1 Yes 2 l	28f. Location	(Street and Numbown, State)	per or Rural Route Number,
	pital o		29a. Certifier Certifying Physician: To the best of r	my knowledge, death	h	antimo data an	d slage, and due to th		
	the Hos in 24 ho the Fun pretely	Medical	(Check only one) 2 Medical Examinar: On the basis of examinar and manner states	camination and/or inv	vestigation, in n	my opinion, dea	th occurred at the time	e, date and place, a	and due to the cause(s)
	To To Com	Σ	29b. Signal de and title of certifier	111		cense number 26652			d (Month, Day, Year)
			Trungaski a quem	in (Hom 20a) T		wo x	pakland	1/40/	XXX
			30. Name and addiess of person who completed cause of deal		Halshus	an K	nkla u D	, md 2	1550
	Sta	ite	31. Date fles (Month, Day, Year) 32. Registrar's	- 1	June	1	dosed		
	Regist	rar	JUL 2 6 2005	6 B	South!				

T wil	-	29b. Signature and title of Certifier				38958	3			(Month, Day, Year) 05 0 2106	
To the Hosp within 24 hou To the Fune completely fil	Medical	(Check only 2 Medical Examone)	nysician: To the best of my niner: On the basis of exa and manner stated.	knowledge, deat mination and/or in	nvestigation, in	my opinion, dea	d place, and th occurred	at the time, dat	e and place, ar	nd due to the cause(s	;)
To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e See Blace of Injury	At home, farm, st	M reet, factory, of	1 ☐ Yes 2 ☐ I		. Location (Stre City or Town,		r or Rural Route Num	ber,
ing ineria		27. Manner of Death 1 Danatural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time o	of 28c.	Injury at Work?	280		v injury occurre		
S S	To B	examiner?	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3 DOA	Other		Check only one 5 ☐ Residen	ce 6 ∐Other	r (Specify)	
	e Completed	25. Was case referred to medical				00 8			pr ed? de	ere autopsy findings for to completion of death? Yes 2 No	
The law requires that the tite has been signed by the bage 2 should be detached.		Part II. Other significant conditions of	contributing to death but no	t resulting in the u	underlying caus	se given in Part I.		23e. Did toba		bute to the cause of d	
death certific e attending p	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 5 No 9 ☐ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregr □ Other (specif				23d. Date Mont	of delivery th Day	Year
sate be executed thysicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cor c. Due to (or as a cor d.								
Inysician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Conjecture as a cor	Heart	ter the mode of	f dying, such as	cardiac or re	espiratory arres	st,	Approximal Interval Bet Onset and	ween
permit. Po Departmer importent eny injury		21. Signature of Funeral Service Licer	Pomara	h 1	2. Name and A 47 Duke	e of Glo	y John oucest	M. Tay er St.	Annapol	eral nome Lis, MD 21	401
eges 1 and 2 nt of Health :: If item 27 i		Walter Goodhue/ 20a. Method of Disposition 1 □ Burial 2 Cremation 3 □	Removal from State	Ob. Place of Dispo cemetery, cre	osition (Name of matory or other		Date	2	0c. Location - C	City or Town, State	
should and Men s marke umetic	ဥ	John T. Flickin 19a. Informant's Name/Relationship (19b. Maili	ng Address (St	treet and Numbe		ude Hod loute Number,		itate, Zip Code)	
tat Hygi d other event,	Be	17. Father's Name (First, Middle, Last,			Homenar	18. Mothe			aiden Sumame		
within 72 ene. then "ne	Completed	(Specify only highest gra		(Give	kind of work d DO NOT use n Homemal	done during most etired)	of working		own H		
permit. Peges 1 and 2 should be lied within 72 hours after death with the maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. See The Maryland See The See The Maryland See	ed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Et	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2♥ No If Yes, Give Year or Dates:		If Yes, specify 1 Yes 2 dent's Usual O		, Puerto Ric		Black	- American Indian, , White, etc. White	
s 23a or	eral Di	210 McKendree A	7		214				United		
r 28a-f s	rector	Maryland Anne A	rundel	Annapoli	S 10f. Zip Co	ode		10	g. Citizen of Wh		2 □ No
how		Usuel Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	ocation					10d. Inside C	
Funeral Director		220-46-0140	□M 2157E	99 Yrs.		ays Hours	Min.	Date of Birth (Month, Day,) Oct. 2,	1905	9. Birthplace (State of Country) New York	r r-oreigi
		Heritage Harbou		iter yrs. last birthday)		apolis	24 Hrs. a	Date of Birth		Arundel	r Famin
/Medic Examin		Jean F. Goodhue 4a. Fecility Name (If not institution, give	e street and number)		4b. City, Tov	wn, or Location o		July 16	2005 4c. County of	11:1	5 p
Physici	an		,					Month	Day	Year	
		1. Decedent's Name (First, Middle, Las	st)				2.	Date of Death		3. Time of	

-04940 [Please Type or Pri		delible lnk. Ens artment of Health	•	
		1 - State Registrar		rtificate of Death		9. No. 2005 25316
Physic /Med		1. Decedent's Nam <i>e (First, Middle, Last)</i> Rosa Deel Golt			July 21	
Exam		4a. Facility Name (If not institution, give street and number, 13590 Oakland Road		4b. City, Town, or Location Ridgely		4c. County of Death Caroline County
Funera Directo		5. Social Security Number 6. Sex 1 M 2X F 7. And 2X F Usual Residence of Decedent	ge (In yrs. last birthday) 76 Yrs.	If Under 1 Year If Under Months Days Hours	8. Date of Birth Min. Month, Day, Aug 27 1	Year) 9. Birthplace (State or Foreign Country) 928 Maryland
ith the Maryland or 28a-f show	tor	10a. State 10b. County Maryland Caroline	10c. City, Town or Lo			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
th the or 28a e notit	Director	10e. Street and Number	Ridgely	10f. Zip Code	10	g. Citizen of What Country?
23a	rai	13590 Oakland Road		21660		U.S.A.
ified within 72 hours after deeth with the Maryland Hygiene. ther then "nature!, or Items 23s or 28s-f show ont, I'm Medical Examinants in Cilifical and the mailting and the m	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	?	Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1 ☐ Yes 2X No Specify	an, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
72 hours "naturel",		15. Decedent's Education	16a. Dece	dent's Usual Occupation		6b. Kind of Business/Industry
d within 72 giene.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 12)	5+) (Give	o kind of work done during mo DO NOT use retired) omemaker	est of working	own home
ges 1 and 2 should be filed within to the Health and Mental Hygiene. If item 27 is marked other then or other traumatic event, II a Mental Hygiene.	To Be	17. Father's Name (First, Middle, Last) Roland R. Boyd			her's Name <i>(First, Middle, N</i> V Dee1	faiden Surname)
and is ma		19a. Informant's Name/Relationship (Type, Print)				City or Town, State, Zip Code)
ges 1 end : it of Heelth if item 27 or other tr		Baynard T. Golt/ son 20a Method of Disposition 1 XBurial 2 Cremation 3 Removal from State	20b. Place of Disponentery, cre	matory or other place)	Date 2	20c. Location - City or Town, State
permit. Pages Department of Himportant: If its	- Auto-	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	2	.11e Cemetery 2. Name and Address of Fac eegle and Hel	ility	
		23a. Part1. Enter the disease, or complications that cause	d the death. Do not en	Box 160 Gree	nshoro MD 2	639
Physiciar /Medica		tmmediate Cause (Final disease or condition resulting in death)	lustre Cert s a consequence of):	israla Dre	a Caplet	Interval Between
Examine		Sequentially list conditions, if any, leading to immediate Due to (or a.	s a consequence of):			, ,
te be executed ysicien and he buriat-transit	cai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C	s a consequence of):			
To the Hospitei or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funerei Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
quires that I n signed by uld be deta	ρ	Part II. Other significant conditions contributing to death	but not resulting in the u	inderlying cause given in Par		accoluse contribute to the cause of death?
To the Hospitei or Attending Physician: The law req within 24 hours after death. To the Funerei Director: Alter this certificate has beer completely filled in by the funeral director, page 2 shou	Completed				24a. Was ar autopsy perform 1 1 Yes 2	prior to completion of cause of
VIIC incian certifi rector	Be	25. Was case referred to medical examiner? **TOTAL STATE OF THE PROPERTY OF T		0	ce of Death (Check only one	
ng Phys ter this	on: To	27. Manner of Death 1 □ Naturat 5 □ Pending 1 □ Naturat 5 □ Pending	ury 28b. Time o		Nursing Home 5 Reside	
Attendir death.	Certification:	2 Accident investigation	nitury - At home, farm, st	Hours 1 Yes 2	No Subject 28f. Location (Str	eet and Number or Rural Route Number,
To the Hospitei or Attendi within 24 hours atter death. To the Funerei Director: A completely filled in by the fu			My	edence	City or Town	Ly Map (and los
he Hos in 24 ho he Fun pletely	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Exeminer: On the basis and manner s	of examination and/or in	th occurred at the time, date a evestigation, in my opinion, de	and place, and due to the ca eath occurred at the time, da	use(s) and manher as stated. ite and place, and due to the cause(s)
To 1 To 1	M	29b. Signature and title of certifier The bull, K	5	29c. License number OCME		d. Date signed (Month, Day, Year) July 22, 2005
		30. Name and address of person who completed cause of	eath (Item 23a) (Type	Print) 111 Penn St	treet Baltim	ore, Maryland 21201

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

			Fo.	State	of Mary	/land /		artment of H			•		ogibic.		
			for State Registrer					rtificate of				eg. No.	005	25317	
I	Physici	an	1. Decedent's Name (First, Mide								2. Date of Deat Month	h Day	Year	3. Time of Death	
	/Medic	cal	Dora		Godwin	1		41. Ch. T.	. 1	-(2 -1)	07	19	2005		
	Examin	ner	4a. Facility Name (If not instituti		edici	12	M	4b. City, Town, o	r Location	of Death		4c. C	ounty of Dea	th IMICO	
-	Funeral		5. Social Security Number	6. Sex		yrs. last b	irthday)	If Under 1 Year		r 24 lys.	8. Date of Birth	14 3	9. Bir	thplace (State or Foreign	7
	Director		213-22-9687	1 □ M 20€	F 77		Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day, 5/6/19)	28	Ma	ryland	
	and .		Usual Residence of Decedent 10a. State 10b. Count	v	10	c. City, To	wn or Lo	ecation						10d. Inside City Limits	
	the Marylar 28e-f show	jo		omico			isb							1 □ Yes 2 No	
	r 28e	Directo	10e. Street and Number					10f. Zip Code			1	0g. Citize	en of What Co	ountry?	_
	be filed within 72 hours after death with the Maryland tal Hygiene. In other than "neturel", or liems 23a or 28e-f show event, the Medical Exacting regal to neithed at	ai D	4820 Meadowlar	ck Dr.				2180	4			U	SA		
	tems	Funerai	11. Marital Status	Arme	Decedent Eve Forces?	r in U.S.	13.	Was Decedent of H If Yes, specify Cuba	lispanic O an, Mexica	rigin? (Spe an, Puerto f	cify Yes or No- Rican, etc.)	14	Race - Ame Black, White		
50	irs aft	by F	1 Never Married 2 Ma 3 Widowed 4 Divorce	If Yes	es 2⊠No ,Give orDates:			1⊡Yes 2XX No	Specify	v:		5	Specify: W	hite	
2-003	within 72 hours after ene. than "neturel", or Ite		15. Decede	nt's Education	ad)	16	a. Dece	dent's Usual Occup	ation	at of working		16b. Kind	d of Business	/Industry	
Ž	ithin 7	ompleted	Elementary/Secondary (0-12)	est grade complet	ge (1-4or 5+)			kind of work done DO NOT use retired	during mo d)	St OF WORKI	ig				
7	lled w tygier ther th	O	10 17. Father's Name (First, Middle	- (act)	•	r	ece	ptionist	19 Mot	anda Nama	(First, Middle, I		pital		_
and		To Be	John Powell	, Lasij							eaucham)		umamej		
ary	s 1 and 2 should be f Health and Mental item 27 is marked other treumatic ev	۲	19a. Informant's Name/Relation	iship (Type, Print)		19	b. Mailir	ng Address (Street	and Numi	ber or Rura	l Route Number	City or	Town, State,	Zip Code)	_
Ξ	rt 2		Carol Jean G	inby/daug	hter		482	20 Meadow	lark	Dr.,	Salisb	iry,	MD 218	804	
o O	ges 1 ar of Hea If item or othe		20a. Method of Disposition 1 ■ Burial 2 □ Cremation	3 □Removal fr	t t	cemet	ery, crer	sition (Name of matory or other place			100		ation - City or		
	t. Pag rtment rtent:		`4 □Donation 5 □Other			Pars		Cemetery		7/22	/05	Sal	isbury	, MD	
g	permit. Pages 1 Department of H Importent: If ite any injury or ot		21. Signature of Funeral Service	sury (ello.		1 I	Name and Addre Molloway 501 Snow	ss of Faci Fune: Hill	ral Ho Rd	ome Proj	fessi	ional A	Association 304	
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that only one cause	nat caused the on each line.	death. Do	o not ent	er the mode of dyir	ng, such a	s cardiac o	r respiratory arr	est,		Approximate Interval Between	ī
	Physician		Immediate Cause (Final disease or condition resulting in death)	a			Pres	imma						Onset and Death	
	/Medical Examiner		resulting in death)	Due	to (or as a co	onsequence			- ,						
		e.	Sequentially list conditions, if any, leading to immediate	b. Due	to (or as a co	onsequence		inalony to	ulm	٤				5 years	_
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1				ASOVA						10 years	
/60,	ate be executed hysician and the burial-transit	i Exi	resulting in death) Last	Due	to (or as a co	onsequence	e of):								
2/89	icate b physic	edicai		d					-					1841	
XOD	certificate nding phys use as the	n/Me	IF FEMALE: 23b. Was decedent pregnant		outcome of p							23	d. Date of de	livery	
	death te atten ed for u	Physician/M	in the past 12 months? 1 □ Yes 2 □ No	4□P	ve birth 2 [regnant at time			Ectopic pregnancy Other (specify)	/			11	Month	Day Year	
r Ö	at the d by th etache	Phys	9 Unknown		nknown										
cords,	wrequires that the death certifics been signed by the attending ph should be detached for use as t	by	Part II. Other significant condi	tions contributing	to death but n	ot resulting	in the u	nderlying cause giv	en in Part	: I.				o the cause of death? robably 4 Unknown	
ဝပ	law re as bee 2 sho	Completed									24a. Was a		24b. Were at	utopsy findings available completion of cause of	
r	The ate h page	Com									perform	ned?	death?		
VII	icien: certific ector,	Be	25. Was case referred to medic examiner?	I I it-l				015		e of Death	(Check only on	е)			
0	Phy r this rat d	: To	1 Yes 2 No		Inpatient ate of Injury		Outpatier . Time of	f 28c Inur	4 🗆 🗅		ne 5 Reside			ocify)	
0	ding P th. : After t	tion	1 2 Natural 5 ☐ Pend	ing (/	ate of Injury Month, Day Ye	ear)	Injury	Wor	k?` Yes 2[000000		
DIVISION	or Attending after death. Director: After in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could	mined 288. P	lace of Injury	- At home,	farm, str	eet, factory, office		2	28f. Location (St City or Town		Number or R	ural Route Number,	_
5	itel or aft ral Di	Cer													
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai	29a. Certifier 1 Certify (Check only 2 Medical	ıl Examiner: On th	the best of more than the basis of example of the contract of	amination a	ge, deati and/or in	h occurred at the tir vestigation, in my o	ne, date a pinion, de	ind place, a eath occurre	and due to the ca ed at the time, d	ause(s) a ate and p	nd manner as place, and due	s stated. e to the cause(s)	
	To th within To th comp	Me	29b. Signature and title of certif					29c. Licens	e number		2	9d. Date	signed (Mont	th, Day, Year)	-
	/ ^		> zue wahn					Dos	735	<i>;</i> .	J	Ny	1915	2005	
	SIM		30. Name and address of perso									1000	- 10- 1-1-1-1		
	Sta	ato.	D.C. US (A NATESAN	1415 2. F distrar's	Signature	V75/0	or ST, S	4USB	uny	70 71	24			_
	Sta Registr		JUL 2	1 2005	Holes	J	4	barle							
							- //								

				ate of Maryland / Dep		Mental Hygier	ne	
			1 - State Registrar	Ce	rtificate of Death	Reg. I	2005	25318
н	Physici	an	1. Decedent's Name (First, Middle, Last) Marlene Patricia Gal.	14		2. Date of Death Month	Day Year	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, give street		4b. City, Town, or Location of De	path 3 lily	4c. County of Death	16:30
			80 North East Isles	Drive	North East		Ceci1	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 H Months Days Hours M	in. (Month, Day, Yea	ar) Coi	nplace (State or Foreign untry)
	Director		Usual Residence of Decedent	65 Yrs.		May 15,19	40 Penn	sylvania
	tryland show	_	10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	Ba-f	Director	Maryland Cecil	North Ea				1 No 2 No
	with t	Dir	10e. Street and Number		10f. Zip Code		Citizen of What Cor	
	death	Funerai			21901 Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu		ited Stat	ncan Indian,
98	or ite	y Fui	1 Never Married 2 Married 1 [TYAS 20XINO	If Yes, specify Cuban, Mexican, Pu 1 ☐ Yes 2 🖾 No Specify:	erto Rican, etc.)	Black, White	·
21215-0036	72 hours after death with the Maryland 'naturel', or Items 23a or 28e-f show died Exacticer must be notified at	ed by	3 ☐ Widowed 4 ☐ Divorced Ÿ _E	ar or Dates:	dent's Usual Occupation	10		
215	nin 72 In "na Medic	piet	(Specify only highest grade com	pleted) (Give	kind of work done during most of v DO NOT use retired)	working 166.	Kind of Business/I	ndustry
21	ed with	Completed	12	Homen	naker	70	wn Home	
Maryland	I be fill hall He other	Be	17. Father's Name (First, Middle, Last)			lame (First, Middle, Maid	en Sumame)	
Ž	should nd Mei mark imatic	ဥ	Leonard A. Clancy 19a. Informant's Name/Relationship (Type, Pr	int) 19b. Maili	Genevie Genevie Genevier or Address (Street and Number or		v or Town State 7	in Code)
	aith ai		Robert Galliera/Husba		rth East Isles D			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: it item 27 is marked other than "naturel; or items 23a or 28a-f show expiritury or other traumatic event, the Medical Examiner must be notified at ance.		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Remove	20b. Place of Dispo	osition (Name of	Date 20c.	Location - City or 1	Town, State
ţ	thent thent tant: I		' 4 ☐ Donation 5 ☐ Other (Specify)	Mayerdare	2	005 Nev	vaik, Dela	ware
Bal	permil Depar Impor eny ir		21. Simalur II uner a Servic II cap ee	1.4 5 5 5 5 5 5		Crouch Fune		1
			23a. Part1. Enter the disease, or complication	s that caused the death. Do not en	27 South Main St er the mode of dying, such as card		last, Mary	Approximate
	Pnysician i		shock, of heart failure. List only one cau Immediate Cause (Final disease or condition	n t	cur			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				years
Ь	LAGIIIIICI	-	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):				
2	uted d ansit	Examiner	cause. Enter Underlying	sub to (or as a consequence or).				
, 0	sate be executed hysician and the burial-transit	Еха		Due to (or as a consequence of):				
8760,		dicai	d					
9 x	leath certific attending p	Physician/Med	IF FEMALE: 23c. If y	res, outcome of pregnancy			92d Data of dalla	
. Box	death e atter	iciar	in the past 12 months?	Live birth 2 Fetal death 3 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of deliver Month	Day Year
P.O.	that the de ed by the detached	Phys	9 □ Onknown	Unknown				
	se ub	by	Part II. Other significant conditions contributi	ng to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacci		the cause of death?
Sor	w require been si should t	letec				-		<u> </u>
of Vital Records,	he lav e has age 2	Completed				24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
ta		BeC	25. Was case referred to medical		26. Place of D	eath (Check only one)	No 1 ☐ Yes	2□ No
<u></u>	Physician: The I this certificate ha ral director, page	٩	examiner? 1 ☐ Yes 2 X No Hospita	1 Inpatient 2 ER/Outpatier	The state of the s		6 ☐Other (Speci	ify)
ouo	ding F h. After funera	tion	1 Natural 5 ☐ Pending	. Date of Injury 28b. Time of (Month, Day Year) Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	ury occurred	
Division	f or Attendi after death. Director: A in by the fu	ifica	3 Suicide 6 Could not be	. Place of Injury - At home, farm, str		28f. Location (Street	and Number or Rui	ral Route Number,
ā	tal or A	Certification:	4 Homicide	building, etc. (Specify)		City or Town, Sta	te)	
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medicai	(Check only 2 Medical Examiner: O	To the best of my knowledge, death in the basis of examination and/or in ad manner stated.	n occurred at the time, date and pla vestigation, in my opinion, death oc	ce, and due to the cause curred at the time, date a	s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and tyle of certifier		29c. License number		ate signed (Month,	
	_		Il forker 1	0	D15314	Jim	420,20	05
	10		30. Name and address of person who complete	ed cause of death (Item 23a) (Type,		D/L+	420,20 By MD	
	Sta	te	St. Date filed (Month, Day, Year)	(250m) Watther	n Cherup cake It	ospice E/KYO	11/10	
**	Registr		JUL 2 1 2005	62. Registrar's Signature	SL "			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended #23a, 24a, 50, cwc, Kent Co. State of Maryland / Department of Health and Mental Hygiene 1-State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year LIAM GRAVE THL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** M PALTI MORE

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
08-10-1918 AND MEDICAL SYSTEM UNIVERSITY MARYI 5. Social Security Number 6. Sex 1∭ M 2□ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** MD 219-07-7218 86 Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mentai Hygiene.
snt: If item 27 is marked other than "natural", or itams 23a or 28a-1 show ury or other traumatic event, the Medical Event at mast to indiffed at 10d. Inside City Limits 1 Yes 2 No Director KENT WORTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11034 Kristin Rd 21678 USA Completed by Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6th NEVER WORKED NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pearl Johnson James Graves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aldridge Dorsey-Nephew 6300 Broadnek Rd Chestertown, MD 21620 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Cemetery, crematory or other place)
Union U.M. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 7/7 /2005 Worton, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kenneth Walley Funeral Service 21. Signature of Funeral Service Licenses aller (W00026) 821 W. St. Annapolis, MD 21401 nt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASPIRATION Agonal /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, here leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to (or as a consequence of) Examiner or Attanding Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760 Completed by Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) be detached 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, renal insufficiency 1 ☐ Yes 2 ☐ No 3 Probably jaundice 24b. Were autopsy findings available prior to completion of cause of death? to common bilectict stepage 24a. Was an autopsy performed? 1 Yes 2 No 2 No 1 XYes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 15 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No larai Diractor: After th 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending s after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funarai (1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ohamo MΔ John 15097 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Brim 22 S. Greene St., Baltimore, MD 32. Registrar's Signature State Registrar 9 2005

			1 - State Registrar	State of Maryla		artment of H			ene g. No. 2005	25320
	Physici		Decedent's Name (First, Middle, Last, Irene	Gra				2. Date of Death Month JULY	3	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give BRADFORD OAK NUR	street and number)	-5	4b. City, Town, o	r Location of Deat		4c. County of Death	
Ī	Funeral Director		5. Social Security Number 6. Se 240-03-8416		s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, Septembe	PRINCE G Year 1904 9. Birth Cou Pr 12 Nor	place (State or Foreign ntry) th Carolina
	e Maryland 8a-f ehow Illied at	ctor	Usual Residence of Decedent 10a. State 10b. County MD Prince Ge		ity, Town or Lo					10d. Inside City Limits 1 √ Yes 2 □ No
	23a or 2	Funeral Director	10e. Street and Number 7520 Surratts Roa	ad		10f. Zip Code 20735		10	g. Citizen of What Cou	ntry?
980	within 72 hours after deeth with the Maryland ene. than "natural", or Itams 23a or 28a-f ehow ha Madical Eyardi er must be nuilitied at	by	11. Marital Status 1 Never Married 2 Married 3 Nover Married 2 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2☑ No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White Specify:	
21215-0036	within 72 ho ene. than "natur he Madical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 6th	cation e <i>completed)</i> College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired omestic	during most of wo	orking 1	6b. Kind of Business/Ir	
Maryland 2	uld be filed Mental Hygi irked othar itlc evant, II	To Be Co	17. Father's Name (First, Middle, Last) Charlie Davis	3			18. Mother's Na Add	me (First, Middle, M ie Reid	laiden Surname)	
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or itams 23a or 28a-4 show any injury or othar traumatic evant, the Madical Examiner must be notified at once.		19a. Informant's Name/Relationship (T) Emmanuel Jenkins/N 20a. Method of Disposition 1⊠ Burial 2 □ Cremation 3 □ F	Nephew 20b.	26 Sc		Place S	wosset N.	City or Town, State, Zi ew York Oc. Location - City or T	11791 own, State Carolina
Baltimore,	permit, Pag Department Important: I any injury o once.		4 Donation 5 Other (Specify) 21. Signatus of Fundal Service Licens	Bro	22		ss of Facility J	3/05 (B. Jenki	Greenville, ins Funeral c, Maryland	North Home
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death)	ne cause on each line. Arteriosc	lerotic				st,	Approximate Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.	quence of):					
x 68760,	ertificate be executed Jing physician and se as the burial-transit	dical	IE EEMALE:	Due to (or as a conse		**************************************				
.O. Box	that the death certificated by the attending for the detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of preging the preging a little pregnant at time of g Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
ecords, P	v requires that been signed I should be det	by	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.		acco use contribute to t	
α	The law ate has b page 2 s	Completed							ed? prior to co death? No 1 Yes	opsy findings available impletion of cause of
on of Vital	ng Phys ter this neral dit	tion: To Be	27. Manner of Death 1 ⊠Natural 5 □ Pending	lospital: 1 Inpatient 2 [28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injury Wor	er: 4 🔀 Nursing H	ath (Check only one Home 5 Resider 28d. Describe how	nce 6 Other (Special	(y)
Division	tan leat tor: the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, sti sify)			28f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,
4	Hospit 4 hour Lunare	Medical (29a. Certifier 1 (Check only one) (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, deat nation and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	e, and due to the cau urred at the time, dat	use(s) and manner as s te and place, and due t	stated. o the cause(s)
4)	To the P within 24 To the C complete	Σ	29b. Signature and title of certifier			29c. Licens) 1943	3/	d. Date signed (Month,	Oay, Year)
			30. Name and address of person who con Frank Ryan M. D.	11701 Livin	gston R		Ft. Was	shington,	Maryland 2	0744
	Sta Registi	_	31. Date filed (Month, Day, Year)	32. Registrar's Sig	Parities					

			1 - For State Registrar Amend# 17	State o	f Marylar , per	nd / Depa FHDR <i>Çe</i> r	artment of I	Health a	and Mental H	ygiene Reg. No. ?	005	25221
ı	Physicia		1. Decedent's Name (First, Middle Einar Gertson	, Last)					2. Date of I Month	Death Day	Year	5-Time of beath 11:35A M
	/Medic Examin		4a. Facility Name (If not institution	, give street and nur	nber)		4b. City, Town,	or Location of		-	ounty of Death	11.33A
			Springhouse				Betheso			Mon	tgomery	7
	Funeral Director		5. Social Security Number 100-01-6070 Usual Residence of Decedent	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs.		If Under 1 Year Months Days		24 Hrs. 8. Date of E Min. (Month, I Nov • 7	Dav. Year)	Cour	place (State or Foreign htry) York
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Be a strong the mary Is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, I'm Madical Examination must be notified at an injury or other traumatic event, I'm Madical Examination must be notified at an injury or other traumatic event, I'm Madical Examination must be notified at an injury or other traumatic event, I'm Madical Examination must be notified at an injury or other traumatic event, I'm Madical Examination must be notified at an injury or other traumatic event, I'm Madical Examination must be not set to be n	Director	10a. State 10b. County Maryland Montgo 10e. Street and Number 4925 Battery La			ty, Town or Lo	10f. Zip Code 20814			10g. Citizer	n of What Cour	Od. Inside City Limits 1 Yes X No
0000	ours after death ral', or Items 23 Exeminet mus	d by Funeral	11. Marital Status 1 Never Married 2 Marri 3 XWidowed 4 Divorced	12. Was Dece Armed Fo	2 (XNo /e		Was Decedent of I	an, Mexicar	gin? (Specify Yes or I	No- 14.	Race - Americ Black, White, Decify: Whit	etc.
7-617	ithin 72 hu ie. ien "natu i Medicel	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education it grade completed) College (1	I-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	durina mos	t of working		of Business/In-	
7	led will have the her		17. Father's Name (First, Middle,	1		Drai	tsman	40.14-11-	de Nove Contract Management		inery	
yland	buld be fi Mental H arked oti atic ever	To Be	Hilamr Gertson-		Gerts	_		Anna	Peterson			
, Mar	and 2 shi		19a. Informant's Name/Relationsl Marlene Cox/dau						er or Rural Route Num #302 Bet			
allimore	Pages 1: ent of He nt: If iten ry or oth		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 4 ☐ Donation 5 ☐ Other (S)		State	cemetery, crer	sition (Name of matory or other pla el Cremat	· 1	Jul ^{Date} 20, 2005		tion - City or To	
De	permit. Departm Importa any inju		21. Signature of Funeral Service	icensee	+	GC GC	2. Name and Addre	ess of Facilit Crem	ation Serv	ice P	.O. Box	•
	Physician /Medical Examiner p private transit	dicai Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to b.	(or as a consector as a consector as a consector)	quence of):	osuff	icie	ncy	u11001,		Approximate Interval Setween Onset and Death
O. BOX 00	The law requires that the death certificate be executed its has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		ointh 2 ☐ Feta nant at time of c	al death 3	Ectopic pregnanc	у		23d	I. Date of delive	e ry Day Year
cords, F	uires that signed b	þ	Post - Polio	Syndr	eath but not res	sulting in the u	nderlying cause gr	ven in Part I.		tobacco use		ne cause of death?
	The la ate has page 2	Completed	Bifascicula	r Heor	+ 31	ock			24a. We aut per 1 Yes	is an 2 opsy formed? 2000	4b. Were auto prior to cor death? 1 🗌 Yes	psy findings available inpletion of cause of
VICA	siciar certifi irecto	o Be	25. Was case referred to medical examiner? 1 Yes No	Hospital:	npatient 2	ER/Outpatien	it 3□ DOA Ot	hac	of Death (Check only rsing Home 5 🗆 Re		Other (Specifi	135,51
0 0	to the Hospital or Attending Physician: within 24 hours after deals, as the centific to the Funeral Director: After this certific completely filled in by the funeral director.	-	27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	28a. Date (Mon		28b. Time of Injury	28c. Inju Wo		28d. Describe	how injury o		Diving
DIVISION	al or Attendi s after death. Il Director: A id in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ned 200. Flace	of Injury - At h ng, etc. (Speci	ome, farm, str	eet, factory, office		28f. Location City or T	(Street and Nown, State)	lumber or Rura	I Route Number,
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edical C	29a. Certifier (Check only one) Certifyin 2 Medical	Examiner: On the b	best of my kno asis of examina ner stated.	owledge, death ation and/or inv	n occurred at the ti vestigation, in my o	me, date an opinion, dea	d place, and due to th th occurred at the time	e cause(s) and e, date and pla	d manner as st ace, and due to	ated. the cause(s)
-	To the To the comp	Me	29b. Signature and tille of certified		<u>پ</u>		29c. Licens D 3	se number	19		igned (Month,	Joos
11)EG		30. Name and address of pers	who completed caus	se of death (Iter	m 23a) (Type,		L. 3	sethesda			
	Sta		31. Date filed (Month, Day, Year)	2005 32.	ogistrar's Signa	ature	Cart in	1		1	-C/1	<u> </u>

Amended Item 23a, Part I, Line b per Physician, 07/15/2005 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** July 13° 2005 Norman Woodward Green 2032 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carroll 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 20 1927 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 XM 2 ☐ F Yrs. 219-20-4176 78 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Carroll 1 XYes 2 No MD Westminster 10e. Street and Number 10g. Citizen of What Country? 345 Pleasanton Road Apt. #23 21157 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Be Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

| Compared to the compared to the 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other then "r Maryland State Elementary/Secondary (0-12) College (1-4or 5+) Sergeant Police 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Green Etta Arnold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21157 permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny injury or other tra once. Betty Green/wife 345 Pleasanton Road Apt.#23 Westminster, MD July 16, 2005 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Surial 2 Cremation 3 Removal from State * 4 □ Donation Cother (Specify) Evergreen Memorial Gardens Finksburg, MD 21. Signature of Funeral Solvice Licensee Prints funerally Home and Chapel, P.A. ali 412 Washington Road Westminster, MD 23a. Pari 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASPIRATION Physician PNEUMONIA LWEEKS /Medical SPINAL CORD STROKE **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 □ Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, multiple myelomA 1 Yes 2 No 3 Probably 4 Unknown Be Completed Amal Pibrillation 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitel within 24 hours at To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WJL I tromas K. Galvis III D31660 14/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HMAS GALVW III 201 5R 12 21157 +12 291 STONEZ AVENUE WESTMINSTEIZ MARHAND

State Registrar

WOODWARD

			1 - State of Maryland / Dep Registrar Ce	artment of Health and M <i>rtificate of Death</i>	, ,		05000
			Decedent's Name (First, Middle, Last)	Timodio of Dodin	2. Date of Death	2005	3. Time of Dealth
	Physici		June Quillin Gnann		Month D	Day Yeer	12:55 P ^M
	/Medid Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		8 2005 4c. County of Death	12:55 P
	LAGITIII	C.	1 Creshaven Dr.	Berlin		Worceste	r
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea		place (State or Foreign
	Director		213-22-7316 1 M 2 F 86 Yrs.	Months Days Hours Min.	6/16/1919		lin, MD
	D .		Usual Residence of Decedent			1 = 9	
	uylar show	_	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	e Ma Aiffe	cto	MD Worcester Berlin				1 ☐ Yes 2 🔀 No
	ih th	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Cou	ntry?
	23a	ra	1 Cresthaven Dr.	21811		USA	
	r dei	Funerai	Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
36	or If	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 12 No If Yes, Give 3 □ Widowed 4 1 □ Divorced Year or Dates:	1 ☐ Yes 2 XXNo Specify:		_ COM	nite
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28a-f show tha Madical Examinat must be notified at			doello Haral Occuration	101	141	
15	n 72 i "na"	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation skind of work done during most of working DO NOT use retired)	ng 166.	Kind of Business/Ir	ndustry
12	d withir giene. r than	m	Elementary/Secondary (0-12) College (1-4or 5+)	okkeeper		Cammun:	h. Clark
9	Hys Hys		17. Father's Name (First, Middle, Last)		(First, Middle, Maide	Communit	Ly Clubs
Maryland	<u>a</u> <u>u</u> <u>u</u> <u>a</u>	o Be	Raymond Quillen, Sr.	Lillian	Filis		
<u>Z</u>	nd 2 should lith and Men 27 is marka	-		ing Address (Street and Number or Rura		y or Town, State, Zij	o Code)
	12 7 Is		Dana Parks/Daughter 1 C	resthaven Dr., Be	elin MD :	21011	
Baltimore,	s 1 and f Heali item 2 other		20a. Method of Disposition 20b. Place of Disposition	osition (Name of Dimatory or other place)	ate 20c.	Location - City or T	own, State
9	permit. Pages Department of h Important: If its any injury or of once.		1 🗆 Burial 2 🕭 Cremation 3 🗀 Hemoval from State	nlopen Crem. 7/19	1/2005 E-	namic fauci	D.E.
=	permit. I Departm Importar any injur	- 1	21. Signature of Fun Service Licensee		he Burbag		
ä	Depariment Department Important in any ir		W. Trik Butos	108 William St., Be	rlin MD	ge Fullera 21811	и поше
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			21011	Approximate
	Physician			ating anut			Interval Between Onset and Death
	/Medical	y	disease or condition resulting in death) Due to (or as a consequence of):	Town Critical			14/10-5
	Examiner		Mitatoti	Colin Comu	1		MTMR
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):				
	be executed sician and burial-transit	Examine	Cause (Disease or injury that initiated events				
0,	an ar rial-t		resulting in death) Last Due to (or as a consequence of):				
8760,	cate be executed obysician and the burial-transit	dicai	d				
9	ng ph ng ph as t	60	IF FEMALE:				
Вох	eath certific attending p I for use as	an/l	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	DEctopic pregnancy		23d. Date of deliv	
	The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as	Physician/M	res allaknoum	Other (specify)		Month	Day Year
P.0	that the de ed by the detached	Phy	9 Unknown				
Ś	res tha	by	Part II. Dther significant conditions contributing to death but not resulting in the	inderlying cause given in Part I.		o use contribute to t	he cause of death?
orc	w require been signature	ted	713000		T Tes	200A0 3 FIO	oadiy 4 Udikilowii
Records,	e law has b	Completed			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
=		Cor			performed?		2□ No
Vital	Icien: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
of	Physicien: this certific ral director,	2	1 Yes 32 No Hospital: 1 Inpatient 2 ER/Outpatie		ne 5 Nesidence		fy)
		lon	27. Manner of Death 1 ★Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 1 Injury	Work?	28d. Describe how in	jury occurred	
Sic	Attending or death. ector: After by the tune	icat	2 Accident Investigation 3 Suicide 6 Could not be		79f Location (Carnet	and Mumber of Chie	
Division	the state of	Certification;	4 Homicide determined 28e. Place of Injury - At home, farm, s	reet, factory, office	28f. Location (Street City or Town, Sta		ai Houte Number,
_	To the Hospital within 24 hours a To the Funerel Completely filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, data and place a	and due to the assu-	(e) and manage	stated
	24 h 24 h e Fur etely	edical	(Check only 2 Medical Exeminer: On the basis of examination and/or in one)	nvestigation, in my opinion, death occurre	ed at the time, date a	and place, and due t	o the cause(s)
	To the Hospital within 24 hours a To the Funerel I completely filled	Me	29b. Signature and title of certifier	29c. License number	29d. E	Date signed (Month,	Day, Year)
	- > E 0		huld M. hum MD	010688		7/19	105
			30. Name and address of person who completed cause of death (Item 23a) (Type			-1/1/	,
8	T 5		Dr. Donald m Wood, MD. 400 1	Eastern Smip I	Dr. Salis	shu u M	d21804
	Sta	ate	31. Date filed (Month, Day, 16at) 32. Pegistrar's Signature	/ 4.	,		
	Regist	rar	31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	and a			

	1 - State Registrar		Cei	rtificate of	Death		Reg. No.	200=	
	1. Decedent's Name (First, Middle,	, Last)				2. Date of D		:005	3. Time of Death
Physician		ieto				Month T1	Day	Year	7 OF -M
/Medical	4- 5-124-14 46 -11-14			4b. City, Town, o	v Loopting of Do	July	11	2005 County of Death	7:35 P ^M
Examiner						am			
	Ginger Cove He			Annapo1				ne Arund	
Funeral		6. Sex 7. Age (In yrs. I	Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	in. (Month, L	Day, Year)	9. Birthp	lace (State or Foreign
Director	225-46-4096	92	115.			Dec. 2	, 191	1 Cana	
D	Usual Residence of Decedent 10a. State 10b. County	10c Cib	, Town or Lo	cation					Od Jacida Obelli is
aryle sho	,	100.00	,, 10 01 20	Cation				'	0d. Inside City Limits
Ba-f	Maryland Anne A	rundel Ann	apolia	3					1 ☐ Yes 2€ No
vith the Marylar or 28a-1 show be notified at Director	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Coun	itry?
3 4 4		ent Drive		21401			Unite	d State	8
of the death of the the transfer of the transf	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	dispanic Origin?	(Specify Yes or N	No- 14	. Race - Americ	an Indian,
T and and and and and and and and and and	1 ☐ Never Married 2 ☐ Marrie	ed 1 □ Yes 2 🛣 No		_		eno rican, etc.)		Black, White,	
d all, o	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 ☑ No	Specify:		S	Specify: whit	e
ed within 72 hor ygiene. her than "natura t, the Midcall	15. Decedent	s Education	16a. Deced	dent's Usual Occup	pation		16b. Kind	d of Business/Inc	dustry
die 'n de	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life. I	kind of work done DO NOT use retire	during most of v d)	vorking			
iene ii witi	Elementary/Secondary (0-12)	2	ħo	memaker			OWN	home	
ant.		ast)			18. Mother's N	lame (First, Midd			
antal H sed ott	Thomas Beddome					eanette		,	
To Be Comple	19a. Informant's Name/Relationsh	in (Time Drint)	105 14-10-						
To, wall yid				ng Address (Street					,
and and mealth m 27 her tr	Helen Maher/ da	ugh ter	607	Admiral	Dr. #204	4 Annapo	lis, N	D 21401	11
d d d d d d d d d d d d d d d d d d d	20a. Method of Disposition 1x Burial 2 ☐ Cremation	3 Demoval from State	lace of Dispo emetery, cren	sition (Name of matory or other place	ce)	Date	20c. Loca	ation - City or To	wn, State
Pages nent of I unt: If its	`4 □Donation 5 □ Other (Sp	ecify) Nav	al Aca	demy Cem	etery 7	-18-05	Anna	apolis,	MD
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra	21. Signatura of Funeral Service L	icensee	22	. Name and Addre	ss of Facility	John M.			1 Home, In
Depa Depa Impo any In	1 X Scatt	- Romassly	14	7 Duke o	f Clouce	ester St	Anna	molis	MD 21401
	23a. Part1. Enter the disease, or	complications that caused the death						, pour do	Approximate
	shock, or heart failure. List of	only one cause on each line.			9,	,			fnterval Between Onset and Death
Physician	Immediate Cause (Final disease or condition resulting in death)	a. Dreumar	110					6	
/Medical Examiner	resulting in death)	Due to (or as a consequ		4					
Examiner	Sequentially list conditions	, dusphac	710	due to	dem	entra			
Je Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to or as a consequ	ence of):						
ansi	Cause (Disease or injury that initiated events								
executed on and ial-transit	resulting in death) Last	Due to (or as a consequ	uence of):						
sicia s bur		d							
icat phy s the		<u>u</u> .							
n certificate be executed nding physician and use as the burial-transit	IF FEMALE:	23c. If yes, outcome of pregna	nev				-		
atten atten I for u		1 Live birth 2 ☐ Fetaf	death 3	Ectopic pregnancy	/		23	d. Date of delive Month	ry Day Year
the day	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 Pregnant at time of de 9 Unknown	eath 5	Other (specify) _					
res that the death signed by the atter be detached for by Physicia	3 Light of the state of the sta							-	
bed bed	Part II. Other significant condition	ns contributing to death but not resu	alting in the ur	nderlying cause giv	ren in Part I.				e cause of death?
daning da	Ochrush III					1 [Yes 2	No 3 ☐ Prob	ably 4 □Unknown
or Attending Physician: The law required from the death. Director: After this certificate has been sim by the tuneral director, page 2 should prification: To Be Completed	hupo Thur	ndism				24a. Wa	is an	24b. Were autor	osy findings available
he la he la se has	1000000					- aut	opsy formed?	prior to con death?	npletion of cause of
icate		1001					2 No	1 🗆 Yes	2 No
ician sertif ecto	examiner?	Hannitat		100		eath (Check only	one)		
hysi this c		Hospitaf: 1 Inpatient 2	ER/Outpatien		ier: 4 X Nursing	Home 5 Re	sidence 6 [☐Other (Specify	<i>'</i>)
ng P ther t nera	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at nk?	28d. Describe	how injury	occurred	
ath.	2 Accident investig	ation			Yes 2 □ No				
Atte	3 Suicide 6 Could n		me, farm, str	eet, factory, office		28f. Location	(Street and	Number or Rura	l Route Number,
tal or Attanding F rs after death. al Director: After ed in by the funers Certification:	4 Literation	building, etc. (Specify	7			City or I	own, State)		
Spinor in	29a. Certifier 1 Certifying	Physicien: To the best of my know	wledge, death	occurred at the tir	me, date and pla	ce, and due to th	e cause(s) a	nd manner as st	ated.
the Hostithin 24 h	(Check only 2 Medical E	xaminer: On the basis of examinat and manner stated.	ion and/or inv	vestigation, in my o	pinion, death oc	curred at the time	e, date and p	lace, and due to	the cause(s)
Fo the complex complex Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date	signed (Month, I	Dav. Year)
F 3 F 8	De Care M	n			44161				
	1004)						Jul	1 14,2	
	30. Name and address of person v	who completed cause of death (Item 2 C O O) M O 2 C O O 32. Registrar's Signat	23а) (Туре,	Print) n 'D.	.k. w.	#1.70	A		10 21401
	MUTICIA C	(9) Mrs 2007	2 rued	near Ha	rivery	610	Anna	POIS M	וט אועטו
State	31. Date filed (Month, Day, Year)	32. Redistrar's Signal	ture	24					
Registrar	JUL 1 4	2005	K	Charle .					

			For State Registrar	State o	f Maryland / D		rtmen tificat				-	giene Reg. N2	0() 5	253	25
			1. Decedent's Name (First, Midd					_		_	2. Date of De	ath		V	3. Time o	f Death
	Physici /Medic		Roy	Milton	Harrison	n					July 1	8, ^{Day}	005	Year	23:	54 м
	Examin		4a. Facility Name (If not institution	on, give street and nu	mber)		4b. City,	Town, or	Location	of Death				of Death		
			Ft. Washingto	on Hospita	1		Ft	. Wa	shing	gton		Pr	inc	e Ge	orge'	3
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last birt	thday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da March	th			lace (State	
	Director		216-50-1342	1 X M 2□ F	56	Yrs.	1710	50,0	1.00.0		March	23,19	149	Bălt	Imore	, Md.
	pu *		Usual Residence of Decedent 10a. State 10b. Count	,	10c. City, Town	n or Lo	cation								Od. Inside C	Mary & Consider
	sho	5												'		2 □ No
	788-f	ect	10e. Street and Number	ce Georges	Ft. W	ası										
	a or	급	2107 Border Dr				10f. Zip	0744				10g. Citiz			•	
	eath	Funeral Director	11. Marital Status		edent Ever in U.S.	12 1				ining (Co	-			Sta	tes an Indian,	
	itan itan	Ę.	1 □ Never Married 2 XMa	Armed Fo	orces?	13. V	Yes, spec	offy Cuba	n, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)		Black	k, White,	etc.	
336	urs el	वि	3 ☐ Widowed 4 ☐ Divorce	If Yes Gi	ve	1	☐ Yes	2€ No	Specify:				Specify:	Blac	ek.	
21215-0036	filed within 72 hours efter death with the Maryland Hyglene. ther than "natural", or items 23a or 28a-f show int, the Modell Examiner must be mailfied at	Completed	15. Decede	nt's Education	16a.	Deced	lent's Usua	al Occupa	ation			16b. Kin	d of Bu	siness/In-	dustry	
218	hin 7	ple	Elementary/Secondary (0-12)	est grade completed) College (1-4or 5+)	life. L	kind of wo DO NOT us	se retired,)	it of work	ing					
21	ad with	Con		College (5+ ' :	Soc	ial W	orke	r			Gov	ern	ment		
pu	be file	Be (17. Father's Name (First, Middle								e (First, Middle		Зитате	e)		
yla	2 should be filed withir and Mental Hyglene. Is markad other than aumatic event, the M	၉	Clifton Milto	n Harrison	1				上1.	та ма	ae Jord	an				
	ges 1 and 2 should be filed within 72 hours efter death with the Marylan it of Health and Mental Hyglene. If itam 27 is marked other than "natural; or itams 23a or 28a-f show or other traumatic event, the Modified at		19a, Informant's Name/Relation	ship (Type, Print)							al Route Numb			State, Zip	Code)	
	of Health of Health itam 27 I		Janice Harris	son / Wife					. Ft	The same of the sa	shingto			2074		
altimore,	Pages 1 nent of H int: if ita		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from		у, стөп	natory or o	ne of ther plac	9)		Oate				wn, State	
Ë	Pa Int		'4 Donation 5 Dother (Specify)	Mt.	OLi	vet		J	uly	2 ⁵ ,200	Wash	iing	ton,	D.C.	
Ball	permit. Pag Department Important: i any injury o		21. Signature of Funeral Service	Licencee	Malas	- 22	Name an	d Addres	s of Facili	ope	Euneral	1 Hom	es.	P.A		
	40244		23a. Part1. Enter the disease	David-	_701085		538	Marl	boro	Pike	Funera Fores	Evill	e,'l	ма:		
Н			shock, or near tallure, Lis	t only one cause on	each line.	not ente	er the mod	e or cryini	g, such as	cardiac	or respiratory a	rrest,			Approxima Interval Be Onset and	tween
}	Physician /Medical		Immediate Cause (Final (disease or condition resulting in death)		erdial inta		ON							60	uple ,	hours.
	Examiner		,	Due to	(or as a consequence	of):									. /	
ш		-	Sequentially list conditions,	b. Typ	Or as a consequence	of):									veral	115.
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause or injury that in its lated a worst.	1 Sim	KiA/6-	0.,.								4	th is	151
	al-tra	xai	that initiated events resulting in death) Last	c. Due to	(or as a consequence	of):									o ge	"/J.
8760,	cate be executed obysician and the burial-transit	alE		L .												
687	fficate g phys	edlo														
ŏ	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnancy							23	3d. Date	e of delive	erv	
Ď.	death a atte d for	Icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregi	ointh 2 Fetal death nant at time of death		Ectopic pr Other (sp						Mon	nth	Day	Year
0	that the de ed by the a deteched t	hys	9 Unknown	9□ Unkn	iown											
a .	The law requires that the site has been signed by the bage 2 should be deteched.	by P	Part II. Other significant condit	ions contributing to d	leath but not resulting in	n the ur	nderlying c	ause give	en in Part I	l.	23e. Did t	obacco us	e contri	ibute to th	ne cause of	death?
Ö	w require been sig should b	pa									1 🗆	Yes 2□] No	3 I Prob	ably 4	Unknown
Records,	aw requisite should	Completed									24a. Was		24b. V	Vere auto	psy findings	available
R	The lav	Eo									auto perfo 1 Tyes	psy ormed? 2 12 No	d	eath?	mpletion of a 2□ No	cause of
		a	25. Was case referred to medic	al					26. Place	e of Deat	h (Check only o				2 140	
>	99	O	examiner? 1 ☐ Yes 2 📉 No	Hospital:	Inpatient 2 ☐ ER/Ou	itpatien	t 3 DC	Othe			me 5 Resi		Othe	er (Specif	v)	
	ig Ph ter th	T :u	27. Manner of Death 1 ⊠Natural 5 □ Pendi	28a. Date	of Injury 28b. T	Time of	2	8c. Injury Work			28d. Describe					
Ö	Attending r death. ector: After by the fune	atlo	2 Accident invest	tigation	,,		M		Yes 2□	No						
Division		tiflo	3 Suicide 6 Could 4 Homicide determ	mined 286. Place	of Injury - At home, fa ling, etc. (Specify)	ırm, str	eet, factory	, office			28f. Location (City or To	Street and wn. State)	Numbe	er or Rura	l Route Nur	nber,
	tai or A rs after al Dire ed in by	Certification;	V		3, (-,,							, σταιο,				
2.	To the Hospital or within 24 hours afte To the Funeral Director completely filled in It	edical	29a. Certifier 1 ☐ Certifyi	ing Physicien: To the	e best of my knowledge pasis of examination an	death	occurred	at the tim	ne, date ar	nd place,	and due to the	cause(s) a	and mar	nner as s	tated.	e)
2)	the the	ledi	one)	and mar	ner stated.					201 00001	00 01 1110 11110,					
	To To	Σ	29b. Signature and title of certifi	er					number	in	Programme Anna Anna Anna Anna Anna Anna Anna Ann	29d. Date	signed	(Month,	Day, Year)	
•			· MMV	L .			V	005	1651	8 -		Ju1y	, 18	, 20	05	
			30. Name and add ss of person					_								
7			John Lee, M		01d Branch	ı Av	re. Te	emp1	e Hil	ls,	Md. 20)748				
	Sta Regist		JUL 2 0 2005	Blow 32.	Registrar's Signature											

			For State Registrar	State of M	arylan	d / Depa	artmer rtifica	nt of H	ealth a Death	and M	ental Hy	giene,	2005	25326
	Physic /Medi		Decedent's Name (First, Middle, Las. John A. Hart	')							July 2		005 Year	3. Time of Death 4:40 p. M
1	Examir	:	4a. Facility Name (If not institution, give Peninsula Regiona.			er		Town, or	Location o	of Death			County of Death	County
di	, Funeral		Social Security Number 6. Security Number	7. Ag	je (In yrs.	last birthday)		r 1 Year	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	th		place (State or Foreign
No.	Director		204-34-1392 Usual Residence of Decedent	A.W 201	59	Yrs.					Feb.4,1	946	Poc	ono,PA
	nyland how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	he Ma 28a-f	Funeral Director	PA Lancas	ter	Pec	<u>juea</u>	104.7	- 0-1-				10- 0:4-	en of What Cou	1 ☐ Yes 2 🛣 No
	3a or 3	i Di	10e. Street and Number 14 Hilldale Rd.				10f. Zi		· =					ntry :
	death	nera	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U	.S. 13.	Was Dece	1756		gin? (Spe	ecify Yes or No Rican, etc.)	USA 1-	4. Race - Ameri	
36	hours after death with the Maryland turel', or Iteme 23a or 28a-f show at Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Xes 2 □ If Yes, Give	No	-	1 ☐ Yes		Specify:		rioari, etc.,		Black, White, Specify: TATH	ite
21215-0036	2 hour atural	led b	15. Decedent's Ed		7	16a. Dece	dent's Usu	al Occupa	ation			16b. Kin	d of Business/In	
215	within 72 ene. than "nai	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or	5+)				tu <i>ring m</i> os)	t of worki	ng			
121	filed w Hygier ther th		11 17. Father's Name (First, Middle, Last)			Owner	:/Ope:	rator		er's Name	(First, Middle		ntractin	ig Co.
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Its Medical Examiner must be notified at	To Be	Harold S. Hart								B. St		,	
ary	2 shou and M is mar aumat	-	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailii	ng Addres	s (Street a	and Numbe	er or Rura	I Route Numb	er, City or	Town, State, Zip	Code)
	l and 2 lealth im 27 l		Constance L. Har	t (Wife)	205 5	14 H	illd	ale F	d., 1	Peque	Ad. PA 1		otion City or T	Ciata
Baltimore,	Pages inent of Hunt: If Ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State		cemetery, crei	matory or	other plac		July	005,		ation - City or To	
altin	permit. Pages Department of I Important: If It any Injury or o		21. Signature of Funeral Service Licen		EV	ans Ea			IL CO	•	red F.		ola,Lanc	.Co.PA
ä	P S E E		Jamas 6	Butter.			234	W.Or	ange				A 17603	
3. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each I	ine.						distast			Approximate Interval Between Onset and Death
	/Medical Examiner	16		b. Due to (or as	a consec	quence of):								
/	te be executed ysicien and te burial-transit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c										
8760,	ate be ex hysicien the buria	icat		d	. 4 00/1300	400100 017.								
Box 6	n certifica anding pl use as t	n/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23	3d. Date of deliv	ery
P.O. B	that the death led by the atter detached for u	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			□Ectopic p □ Other (s						Month	Day Year
	The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	b	Part II. Other significant conditions of	ontnbuting to death t	out not res	sulting in the u	Inderlying	cause givi	en in Part I	l.		tobacco us Yes 2□		he cause of death?
Vital Records,		Completed									24a. Was auto perio 1 Yes		24b. Were auto prior to co death? 1 21 Yes	opsy findings available ompletion of cause of
/ita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				0,5		e of Deat	(Check only	one)		
of	Phys this ral dii	2:	1 ☑ Yes 2 ☐ No 27. Manner of Death	Hospitat: 1 Inpati		ER/Outpatie			4 🗆 190		me 5 Resi		Other (Speci	(y)
ion	Attending in death.	ation	1 Natural 5 ☐ Pending 2 Naccident investigation	28a. Date of Inj (Month, Da	y Year)	Injury	м	28c. Injun Worl	k? Yes 2□					
Division	5 분 등 드	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of to building, e	tury - At h	iome, farm, st fy)	reet, facto	ry, office				Street and wn, State)	Number or Rur	al Route Number,
	To the Hospitel or within 24 hours after To the Funeral Direction completely filled in	edicai (29a. Certifier 1 Certifying Ph (Check only one) 1 Medical Exam	ysicien: To the best niner: On the basis of and manner s	of examina	owledge, deat ation and/or in	th occurred	d at the tin n, in my o	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) a date and	and manner as s place, and due t	stated. to the cause(s)
	To the Vithin To the Comp	M	29b. Signature and title of certifier				29	oc. Licensi					signed (Month, 25, 20	
			Hundt Buth	4, MD								Jury		
	10		30. Name and address of person who	completed cause of	death (Ite	m 23a) (Type,	Print)	Penr	n Stre	eet	Baltim	ore,	Marylan	d 21201
	St	ate	31. Date filed (Month, Day, Year)	32 Regist			-							
	Regist	trar	AUG 0 3 201	05 /	/	K Lo	call !							

			For State	State of Ma	-		rtment of H		lental Hy	_	000-	
_	_	46	Registrar 1. Decedent's Name (First, Middle, Las	41		7611	illicate of t	Jealii	0.000-40	Reg. No	2005	25327
	Physici		Dieter Will	•	perger				2. Date of D		^y 2005 ^{Year}	9:46P M
	/Medic		4a. Fecility Name (If not institution, give		9-		4b. City. Town, or	Location of Death			. County of Dea	
	Examil	161	VA MARYLAND HEAL		STEM		PERRY				CECIL	411
	Funeral		5. Social Security Number 6. Se		(In yrs. last birtho	day)_	If Under 1 Year	If Under 24 Hrs.	8. Date of B			rthplace (State or Foreign
	Director		217-50-6039 Usual Residence of Decedent	M M 2□F	56 yr	s.	Months Days	Hours Min.	8. Date of B (Month, D FeD.	4 , Year	949 G	ermany
land	MO TO		10a. State 10b. County		10c. City, Town o	or Loc	ation					10d. Inside City Limits
іе Мал	8a-f sh	Director		ford	Aber	de	en					1 🗗 es 2 □ No
U Z I Z 13-0000 flad within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Importent: or Items 23s or 28a-f show Importent: If Item 271s marked other then "natural", or Items 23s or 28a-f show any injury or othar treumetic event, the Modeal Examinet must be notified at 20cs.	ai Dire	10e. Street and Number 81 Mt. Royal	Avenue			10f. Zip Code 2100)1		10g. Cit	izen of What C	
deat	E ams	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. W	as Decedent of Hi	ispanic Origin? (Sp	ecify Yes or N	0-	14. Race - Am	
urs after	if, or ite	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 X Yes 2 □ N If Yes, Give Year or Dates: V	o Tietnam		Tes, specify Cuba ☐ Yes 2 No	n, Mexican, Puerto Specify:	rican, etc.)		Black, Wh	
2 hot 2	atura ical E		15. Decedent's Ed	ucation	16a. D	ecede	ent's Usual Occupa	ation		16b. K	ind of Busines:	s/Industry
within 7	hen "r hen "r	Completed	(Specify only highest grad	College (1-4or 5-	+)	fe. D	ina or work aone d O NOT use retired oment ope	•	ing		civil Se	ervi <i>c</i> e
llad v	Hygie ther t nt, in		17. Father's Name (First, Middle, Last)		174	լևու	Allerie Ope	18. Mother's Name	e (First Middle			
uld be	vental irkad o	To Be	William Her	zberger					Romig	, maideir	Sumame	
Mal) of 2 sho	Ith and Ith		19a. Informant's Name/Relationship (7 Mrs. Edith McFade				Address (Street a	and Number or Rura Ave.,	Aberde	er, City o	r Town, State, Marylai	Zip Code) nd 21001
<u> </u>	tem tem		20a. Method of Disposition		20b. Place of D	ispos	ition (Name of		Date	20c. Lo	ocation - City o	r Town, State
Dallellici Jermit. Pages	nent of ant: If I ary or		1 ☐ Burial 2 🔀 Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify				atory`or other plac ris & Co.		/05	West	Cheste	er, PA
part.	Departi Import any inj		21. Signature of Funeral Service Licen:	11/1/10/c	1 & ADER	²² ,	ame and Addres Carring-C Loerdeen	s of Facility Cargo Fun Marylan	ral 100	те ₃₃	₿9 ^A •	
15		7.5	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olic tions that caus	the death. Do not					rrest,		Approximate Interval Between
	ysician Medical		Immediate Cause (Final disease or condition resulting in death)	ASPIRATI	ON PNEUM		IA					UNKNOWN
	kaminer				consequence of)		ER OF SO	FT PALATE	AND			UNKNOWN
		e	Sequentially list conditions if any, leading to immediate	b	consequence of)			LOTTIC LA		-		Orticionit
cuted	ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	c								
ficate be executed	physician and s the burial-transit	Exa	resulting in death) Last	Due to (or as a	consequence of)	:						
cateb	chysic the b	edicai		d								
law requires that the death certific	ittending or use a	hysician/Me	in the past 12 months?	23c. If yes, outcome of	2 Fetal death		Ectopic pregnancy				23d. Date of de	livery Day Year
i e d	ad by the a detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	ime or death	5 🗀 (Other (specify)			8		,
s that	ignad b	by Pt	Part II. Other significant conditions co	entributing to death bu	t not resulting in th	ne und	derlying cause give	n in Part I.	23e. Did	obacco u	ise contribute t	o the cause of death?
duire	0) 123		RESPIRATORY FAILU	RE, CORONA	ARY ARTER	RY .	DISEASE,		10	Yes 2	□No 3□P	robably 4 🛮 Unknown
e law re	S CA	Completed	CONGESTIVE HEART	FAILURE					24a. Was	DSV	24b. Were a	utopsy findings available completion of cause of
n: The	pag								1 Yes	rmed? 2⊠ No	1 Ne	s 2 No
Physician:	h. Aftar this certific funaral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	a∏58/0	ntio-1	20 DOA Othe	26. Place of Death			- Four :5	
2 F	ar this aral dii		27. Manner of Death	28a. Date of Injury	/ 28b. Tim	ne of	3 ☐ DOA 28c. Injury Work	4 Nursing Ho	me 5 ∐ Resi 28d. Describe			ecity)
ending	leath. tor: Aftar the funar	ation	1 Natural 5 Pending 2 Accident investigation		Year) Inju	iry		? /es 2 □ No				
el or Att	oliter of Direction by in by	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc.	ry - At home, farm (Specify)	, stree	at, factory, office		28f. Location (City or To	Street and wn, State	d Number or R)	ural Route Number,
Hospit	24 hours a Funerel I	dical C	29a. Certifier 1 X Certifying Phy (Check only one) 2 Medical Exam	vsician: To the best of iner: On the basis of	f my knowledge, dexamination and/o	death o	occurred at the timestigation, in my op	e, date and place, a inion, death occurr	and due to the ed at the time,	cause(s) date and	and manner a	s stated. e to the cause(s)

2+1

SUKH DEV S. AUJLA, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND 21902

29c. License number

D19402

29d. Date signed (Month, Day, Year)

JULY 29, 2005

31. Date filed (Month, Day, Year)

29b. Signature and title of cer

AUG 0 3 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				For State Registrar	State o	f Marylar	-	artment of H		lental Hygie	ne n2 ()	05	25320
				Decedent's Name (First, Middle, La	est)					2. Date of Death		00	3. Time of Death
		Physicia /Medic		Lois	Gay	Hamli	n			July 27,	^{Day} 2005	Year	5:15pm [™]
		Examin		4a. Facility Name (If not institution, gir					Location of Death		4c. Count		
				Homewood @ Crum]			to an include of the	If Under 1 Year	ederick	O Data of Dist		rede	
		Funeral Director			Sex 1 □ M 2 🔀 F	7. Age (In yrs.		Months Days	Hours Min.	8. Date of Birth (Month, Day, Yo Nov 7, 1	915	Vira	place (State or Foreign Intry) Sinia
				Usual Residence of Decedent						1107 7, 1	713		
	arylan	show	_	Maryland Fred	erick	10c. Ci	ty, Town or Lo Frede						10d. Inside City Limits 1 XYes 2 No
15	he M	Pag-f	Director		el ick		rrede				0''	14/1	
6	1215-0036 within 72 hours after death with the Maryland	el', or items 23a or 28a-f show Erbulnet must be notified at	ai Dir	10e. Street and Number 221 East Second	Street			10f. Zip Code	21701	109.	Citizen of U	S.A.	
~	ar dea	or items	Funerai	11. Marital Status	Armed Fo		LS. 13. Y	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Spo n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Ameri ck, White,	can Indian, , etc.
2	36 rs aft	i, or	by F	1 ☐ Never Married 2 ☐ Married 3 XXVidowed 4 ☐ Divorced	1 ☐ Yes If Yes, Giv Year or D	/e		1 ☐ Yes 2💢 No	Specify:		Specif	fy: Wh	nite.
7	5-0036	ature		15. Decedent's E	ducation		16a. Deced	dent's Usual Occupa	ation	16	o. Kind of 8		
\	215 ithin 7	ene, then "n ie Med	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1	-4or 5+)	life. I	DO NOT use retirea	during most of work	ing			
	N	lygiene her the it, lite		12 17. Father's Name (First, Middle, Las.	41		Но	memaker	40. Mathada Nama	/First Middle Mai		Home	3
3	Maryland d 2 should be file	and Mental Hygie is marked other t reumatic event, IL.) Be	Roger Pendl	-	Redmo	ond		Bettie	e (First, Middle, Mai	Bail		
10	ITY I	th and Mer 7 is marke treumatic	오	19a. Informant's Name/Relationship				ng Address (Street a		al Route Number, C			Code)
18	Ma Ind 2	alth an 27 is i		Mr. David M. Fir	or/Neph	ew	11533	Hessong	Bridge D	r, Thurmo	nt Ma	rylar	nd 21.788
1	ore,	Department of Health importent: if Item 27 I any injury or other tre		20a. Method of Disposition 1 XBurial 2 Cremation 3	Demoval from	20b. I	Place of Dispo	sition (Name of matory or other plac	е)	Date 200	. Location	- City or T	own, State
·	Baltimor	ment lent: i		`4 □ Donation 5 □ Other (Speci	ify)		versid	e Mem Par	k Aug 1	, 2005 N	orfol	k, Vi	irginia
0	Balt Dermit	Depart mpor any in ance.		21. Signature of Funeral Service Lice	10 \	\		Keeney &	& Basford	P.A. Fun	eral	Home	
0		0.2 4 0		23a. Part NEnter the Chellse, or con	nolications that o	MOO706	th Do not ent	06 East (hurch St	, Frederi	ck, M	aryla	and 21701
1		34.14		shock, or heart froure. List only Immediate Cause (Final	one cause on	ach line.				who De			Interval Between Onset and Death
		hysician Medical		disease or condition resulting in death)	a Due to	or as a consec	nuence of):	e con	sco vize	word Da	and k		Syrp,
3	E	xaminer		Comments the float considering	h		(30,000,00)						*
3	1/2	- 5	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	or as a consec	quence of):						
-g	A ecute	ohysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c	or as a consec	mence of).					-	
X	60,	ician buria				01 43 4 001300	(Berice Oi).						
. 3	687 ilicate	phys	edicai		d								
35	OX (attending p	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out			De ataula autonomo.			23d. Da	ate of deliv	ery
.0	ords, P.O. Box 68760, <	the atte	Physician/Me	in the past 12 months? 1 Yes 2 No		irth 2 ☐ Feta ant at time of c		Ectopic pregnancy Other (specify)			Mo	onth	Day Year
à	P.C.	ad by the detached	Phy	9 Unknown	N - M		laine in abo	ada bisa sa sa sa	an in Dawl	220 Did tohoo		telleute te t	he cause of death?
3	ds,	signed be de	l by	Part II. Other significant conditions	contributing to a	ath but not res	suiting in the u	nderlying cause give	en in Parti.	1 ☐ Yes	2 X No		bably 4 Unknown
4	COL		letec					·		24a. Was an	24h	Were auto	opsy findings available
5	Rec The Lev	CE CO	ompieted							autopsy performed	13-	prior to co death?	impletion of cause of
3			e C	25. Was case referred to medical					26 Place of Death	1 Yes 2	No	1 🗌 Yes	200 No
9	of Vita	<u>v</u> 0	ro B	examiner? 1 ☐ Yes 2 🗽 o	Hospital:	npatient 2	ER/Outpatier	t 3 DOA Othe		me 5 Residenc	e 6 🗆 Oth	her (Specif	(y)
20	ono ding Ph	h. After th funeral	:uo	27. Manner of D ath 1 ★Natural 5 □ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	Work	at k?	28d. Describe how			
27	Vision	death. ctor: A y the fu	cati	Accident investigation	he -	-61-1 Ax la			Yes 2 □ No	204 Laustine (Ctros	A A / 1	has as 0	al Courte Abreele
3	5 5	Direc Direc J in by	Certification;	4 Homicide determined	d 286. Place buildi	ng, etc. (Speci	fy)	eet, factory, office		28f. Location (Stree City or Town, S		oer or Hura	II Houte Number,
Knowy	To the Hospitel	within 24 hours after death To the Funerei Director: completely filled in by the	edicai C	(Check only Medical Exa	miner: On the b	asis of examina	owledge, death	n occurred at the tim	ne, date and place, a pinion, death occurr	and due to the caus ed at the time, date	e(s) and m and place.	anner as s	itated. o the cause(s)
3	the	thin 2 the l	Med	29b. Signature and title of certifier		ner stated.		29c License					Day, Year)_
	ř	ĭ ¥ ¥ 8		> X about	1/7	Corto	m	D	-13971	A	1/3	0/0	25
				30. Name and address of person who	completed caus	se co eath (Ite	m 23a) (Type,	Print)	- /		/	, 0	_
		B		Robert L. Kaufma	ann, M.D	., 300	West N		et, Frede	erick, Ma	rylan	d 217	'01
	124	Sta	te	31. Date filed (Month Day Year)	2005 32.	gistrar's Sign	atura A	raste)					

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of He <i>rtificate of E</i>			ene g. No.2 () () = 2 = 2 = 2
	4. A.	ei i	Decedent's Name (First, Middle, La	st)				2. Date of Death	1 _	3. Time of Déath
	Physici /Medic		JOAN LOUISE HOL	LOWAY				Month July	15 200	05 8:18 P M
	Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of Death		4c. County of	
¥,	State.		Doctor's Communit			Lanham				George's
	Funeral		5. Social Security Number 6. S	□M 2XTE	(In yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 3,	Year)	Birthplace (State or Foreign Country)
	Director		577-48-5685 Usual Residence of Decedent	(59 Trs.			April 3,	1936 V	Washington, DC
	yland		10a. State 10b. County		10c. City, Town or L	ocation			· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits
	Mar Mar	ctor	MD Prince G	eorge's	Hyattsvi:	l1e				17∏ Yes 2 □ No
	th the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	at Country?
	death with the Maryland ms 23c or 28a-f show Lister Letter Life of A	rai	5004 Crittenden S	treet		2078	1		U.S.A.	
30	d within 72 hours after death with the Marylan giene. ir than "natural", or Itams 23c or 28a-f show It e Marilon Externity is at the recilition at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2X No	spanic Origin? (Sp. n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
3-003 <i>a</i>	2 hou	per	15. Decedent's Ed	ducation	16a. Dece	dent's Usual Occupa	tion	1	6b. Kind of Busin	White ness/Industry
2	within 73 ene. than "n	Completed	(Specify only highest gra	de completed) College (1-4or 5-	(Give	kind of work done du DO NOT use retired)	uring most of work	ing		,
7	filed within Hygiene. other then	Com	12	Conege (1-40) 3		emaker			Own Hor	ne
yland	be filed stal Hygie d other avant, I	Be	17. Father's Name (First, Middle, Last,				18. Mother's Name	(First, Middle, M.	aiden Sumame)	
<u> </u>	2 should be and Mental Is markad sumatic av	으	William Archer Pu					ne Rita :		
	s 1 and 2 should f Health and Men itam 27 is marks other traumatic		19a. Informant's Name/Relationship (ng Address (Street at				
e,	s 1 and if Health itam 27 other tra		Grace M. Caton, S 20a. Method of Disposition	Sister		6th Stree				21225 ty or Town, State
	Pages nent of h int: If its		11∑ Burial 2 ☐ Cremation 3 ☐	Removal from State		osition (Name of matory or other place				
Dallimor	# 문화를		* 4 Donation 5 Other (Specifical Service Licer							am, Maryland
מ	permi Depa Impo any ir		A Land		1 11	2. Name and Address				•
-	8 8		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused						, Maryland Approximate
	Pnysician		Immediate Cause (Final							Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		ocardial consequence of):	iniarction	1			
	Examiner		Constant for the second bloom	b. Hyperten	sive Card	iomyopathy				
	- =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		consequence of):					
	acute and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	C						11/11
Š,	oe exician sourial.	Ē	resoluting in death) cast	Due to (or as a	consequence of):					
00/00	ficate be executed g physician and as the burial-transit	edicai	•	d						
_		ian/Me	IF FEMALE:	23c. If yes, outcome of	of pregnancy				224 D-10	4 - 1
.O. DOX	The law requires that the death certifule has been signed by the attending rage 2 should be detached for use a	hysiciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	
Ž.	s thai	by P	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the u	nderlying cause giver	n in Part I.	23e. Did toba	acco use contribu	ute to the cause of death?
ğ	equire en sig	ed	Chronic Renal Ins	sufficiency	·	-		1 ☐ Yes	: 2 X ∏No 3	☐ Probably 4 ☐ Unknown
i necoras,	e la has	Complet	Chronic Obstruct	ive Pulmona	ry Diseas	e due to A	Asthma	24a. Was an autopsy performs	prio ed? dea	re autopsy findings available or to completion of cause of th? Yes 2 \sum No
<u> </u>	sician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place of Death	(Check only one)		
5	Physic this c	2	1 ☐ Yes 2X No	Hospital:			4 Nursing Ho	ne 5 🗆 Residen		
	ding Physician: h. After this certific funeral director,	ertification:	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Work?		28d. Describe how	injury occurred	
VISIO	Attandi death. ctor: A y the fu	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b		y - At home, farm, st		es 2 No	28f Location /Stre	et and Number	or Rural Route Number,
2	al or Attano after deatl Diractor: d in by the	ertii	4 Homicide determined	building, etc.		eer, ractory, ornice		City or Town,		or north north number,
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Diractor: After this certific completely filled in by the funeral director.	edicai C	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of niner: On the basis of and manner state	examination and/or in	h occurred at the time vestigation, in my opi	e, date and place, nion, death occurr	and due to the cau ed at the time, dat	use(s) and manne e and place, and	er as stated. If due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	R. 1		29c. License	number	290	d. Date signed (#	Month, Day, Year)
	~		> Muhail	Mand	, nu	D2628	37	J	uly 17,	2005
UI	Ma		30. Name and address of person who						36 - 3	1 207/0
	Sta	to	Michael Berard, 1 31. Date filed (Month, Day, Year)	30 Registra	Baltimore 's Signature)/, Colle	ge Park,	Maryla	nd 20740
	Registr	_	JUL 2 0 200	5 Bleeve	1 Apr	de				
		46	4 N V							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Thomas Gonsalvo Hodges IV Ju1y 24 2005 8:30 A. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's 22680 Cedar Lane Court, Apt. 218 Leonardtown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**∑**M 2□F 92 577-14-1805 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or itama 23a or 28a-f shov other traumatic event, the Medical Examples main to notified at 1X Yes 2 □ No Directo Maryland St. Mary's Leonardtown 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 22680 Cedar Lane Court #218 20636 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: White þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Menial Hygiene. Important: if item 27 is marked other than "nt any injury or other traumatic event, the Media 2006. College (1-4or 5+) Elementary/Secondary (0-12) Food Service 12 Meat Cutter/Grocer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Thomas Gonsalvo Hodges III Virginia Gibson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Patricia McCarthy 6908 Fairfax Dr. #210, Arlington, VA 22213 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery July 27, 2005 Silver Spring, Maryland 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A., 21. Signature of Funeral Service Licenses P. O. Box 270, Leonardtown, MD 20650 Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part1 Enter the disease, shock, or heart failure. List only one cause on each lir Immediate Cause (Final disease or condition poucetto perice **Physician** splanaresulting in death) /Medical Examiner Sequentially list conditions, Due to for as a consciouence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed burial-transit and Due to (or as a consequence of): attending physician Physician/Medical as the esn IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Day Month jo in the past 12 months? 4☐ Pregnant at time of death 5 ☐ Other (specify) Yes 2 No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by should be 1 🗌 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed' 2 No 1 Yes 2 🗆 No 1 ☐ Yes or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specific McC 1 ☐ Yes 2 ☑ No P 1 Inpatient 3 DOA 2 ER/Outpatient 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Medical Certification; After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours efter deati To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DO 13

State Registrar 31. Date filed (Month, Day, Year) JUL 2 6 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			For State	State of Mar		partment of H		-	ene	07001
			Registrar 1. Decedent's Name (First, Middle, L		Ce	ertificate of	Death		. No.2005	~ ~ ~ ~ ~
	Physici	an	Don Robert Hesso					2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, g.			4b. City, Town, o	or Location of Death	Jum?	4c. County of Dea	
н			17429 Gay Street			Hagerst	rown		Washingto	on
	Funeral			Sex 7. Age (In yrs. last birthda		If Under 24 Hrs.	8. Date of Birth (Month, Day, Y	9. Bir	thplace (State or Foreign
	Director		214-28-0516 Usual Residence of Decedent	724 W 2 U 1	71 Yrs.			Oct. 15,1	933 Mar	~yland
4	ylend F F		10a. State 10b. County	1	0c. City, Town or	Location				10d. Inside City Limits
	e-f st	ctor	Maryland Washi	ngton	Hagerst	own				1 ☐ Yes 2 🕍 No
4	or 28	Funeral Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	ountry?
4	s 23a	rai	17429 Gay Street	140 144- 0		21740	11	7. 7.	USA	
	itam	-E	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No		If Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, Whit	
3	nours aner deam win me marylend turel', or itams 23a or 28e-f show al Examinar must be notified at	þ	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify: Wh	nite
က်	2 8 9	Completed	15. Decedent's I (Specify only highest g		16a. Dec	edent's Usual Occup	pation during most of work ed)	ing 16	b. Kind of Business	/Industry
2	within than "t	m	Elementary/Secondary (0-12)	College (1-4or 5+)			·d)			
SVI 3	Hygie other 1		17. Father's Name (First, Middle, Las	4	Inst	ructor	18. Mother's Nam	e (First, Middle, Ma	Sovernment iden Sumame)	<u> </u>
	e d la	To Be	Robert Milton He	ssona					Ausherman	
ary	and Men is marks eumatic	-	19a. Informant's Name/Relationship		19b. Mai	ling Address (Street	t and Number or Run			
	12 € Z	ं	Katrina Huggins	(Daughter)			e Dr. Col		, TN 3801	7
ore	90=5		20a. Method of Disposition 1 ☐ Burial 2 🎖 Cremation 3	☐Removal from State	20b. Place of Disp cemetery, cr	position (Name of ematory or other pla	ice)	Date 20	c. Location - City or	Town, State
	- # # # ·		*4 □ Donation 5 □ Other (Spec	eify)	Smithsbu	rg Cremat	ory July	23,2005 S	mithsburg	, Maryland
Ba	Dep Imp		De itte	164		Osborne F	uneral Ho amsport,	me P.A. 4	25 S. Con	ococheague
			23a. art1. Enter the disease, or con	nplications that caused th	e death. Do not e					Approximate
P	hysician		shock, or heart failure. List onl Immediate Cause (Final disease or condition	y one cause on each line.	067	+ Man	- Vhall	0		Interval Between Onset and Death
	/Medical	П	resulting in death)	a,Due to (or as a	nsequence of):	1100	o i reel	STAN	VI '	7 months
	Examiner		Sequentially list conditions.	b /5 b	esto	212	•		>	15 years
7	nslt	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence oi):					0
•	be executed slcien and burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
760	deam centilicate be executed e attanding physicien and d for use as the burial-transit	call		d						
89	ing ph		IF FEMALE:							
Вох	attanding p	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2	Fetal death 3	☐Ectopic pregnance	у		23d. Date of del Month	livery Day Year
		ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tir 9□Unknown	me of death 5	Other (specify)				
<u>a</u>	ine law requires mat me ate has been signed by th page 2 should be detache		Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause giv	ven in Part I	23e. Did tobac	co use contribute to	the cause of death?
rds	w requires inat been signed b should be deta	ed by	peri	cardia	Vinv	olvem	cent,	1 🗆 Yes	2 □ No 3 □ Pr	robably 4 Unknown
ecords,	aw rens bee	piet	a Hotro	Reniton	vi Usao	oulour	mont	24a. Was an	24b. Were at	utopsy findings available
		Completed				1000	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	autopsy performe 1 Yes 2	d? death? XNo 1 ☐ Yes	completion of cause of
Vita	certificate	Be (25. Was case referred to medical examiner?					h (Check only one)		
ot	this c	2	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient		BIL 3 DOA	her: 4 Nursing Ho	me 5 Lesidend 28d. Describe how	e 6 ☐Other (Spe	cify)
ם ק	h. After funera	tion	1 Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day)	(ear) Injury	Wor	rk?]Yes 2 □No	20d. Describe flow	mjury occurred	
Division	r death.	ifica	3 Suicide 6 Could not determine	be 28e. Place of Injury	- At home, farm, s	treet, factory, office			et and Number or Ru	ural Route Number,
	rs afte rs afte et Dir ed in l	Certification:	4 D Homicide	building, etc.	(Бреспу)			City or Town, S	state)	
1	to the nespital or Attending Frigstrant, within 24 hours after death. To the Funarel Director: After this certific completely filled in by the funeral director,	edical ((Check only 2 Medical Exa	Physician: To the best of aminer: On the basis of e	xamination and/or i	ath occurred at the tir	me, date and place, opinion, death occurr	and due to the caus	e(s) and manner as and place, and due	s stated. e to the cause(s)
4	ithin 2 o the	Med	29b. Signature and title of certifier	and manner state	d.	29c. Licens			. Date signed (Monti	
F	- 3 ⊢ ŏ		MA L	to.	1	11	14614	3	July 2	12,2005
			30. Manh and address of person who	completed cause of plea	th (Item 23a) (Type	p. Print)	MON		1	21740
2.	-8		Hind Ha	sunda	m, me	D: 113	O OPA	L CT.	Hagen	My nwota
	Sta		31. Date filed (Month, Day, Year) JUL 25	2005 32. Registrar's	s Signature	breeks			1	
	Registr	ar	30L 40	-000	- ~ /					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydion 2005

		•	For State Registrar	Maryland / Depa	rtificate of D	eath		g. No.	23332
Ė	Physicia	an	1. Decedent's Name (First, Middle, Last) Jeanne Rose Hill				2. Date of Death Month July	Day 2005	3. Time of Death 3:15 PM
	/Medic		Jeanne Rose Hill 4a. Facility Name (If not institution, give street and nun		4b. City, Town, or L	ocation of Death	July	4c. County of Deat	
H			801 Diamond Drive		Gaither	-		Montgome	
	Funeral Director		342-16-5956 1□M 212 F	7. Age (In yrs. last birthday)	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 20	9. Birt 1923 I11	hplace (State or Foreign untry) Lnois
/land	Mo to	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
e Man	la-f sh	ctor	Maryland Montgomery	Gaithe	rsburg				1 XYes 2 □ No
h with th	23a or 26	Funeral Director	10e. Street and Number 801 Diamond Drive		10f. Zip Code 20878	1	10	og. Citizen of What Co United Sta	*
after deat	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant, the Medical Evant estrains for collided at once.	/ Funer	Armed Fo 1 □ Never Married 2 Married 1 Never Married 2 Married 1 Never Marrie	2□No 1944-	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 No	panic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: TIT	e, etc.
d within 72 hours af	furaf,	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Divorced 15. Decedent's Education	16a Dece	adent's Usual Occupati	on		6b. Kind of Business/	nite
6 17 St nid	en "na Medic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1	-4or 5+) (Give	e kind of work done du DO NOT use retired)	ring most of work	ing		
 	lygien her tha	Con	12 17. Father's Name (First, Middle, Last)	Hai	r Stylist	9. Mothode Nam	e (First, Middle, N	Beauty Sa	lon
yland buld be file	e∩tal ⊬ kad ot ic avar	To Be	James Short		'		cia Nucc		
Mary d 2 shou	Ith and Mi 27 is mark traumati	-	19a. Informant's Name/Relationship (Type, Print) Thomas E. Hill / Husba		ing Address (Street an Diamond D				
Daitimore,	of Hea		20a. Method of Disposition 1 □ Burial 2 🏋 Cremation 3 □ Removal from	20b. Place of Disp cemetery, cre	osition (Name of ematory or other place)	Ju1y	Date 2	20c. Location - City or	Town, State
TITTE	rtment rtant: njury		*4 □ Donation 5 □ Other (Specify) 21. Signature of uneral Service Licensee	Metropol:	itan Crema 22. Name and Address	,5		Alexandria eral Home	, Virginia
ם פ	Depa Impo any i		21. Signapile Willeran Solvice Licenson		0 E. Deer			eral nome ersburg, M	20877
			23a. Part1. Enter the disease, or complications that c shock, or heart failure. List only one cause on e	aused the death. Do not er ach line.	nter the mode of dying,	such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	nysician Medical		Immediate Cause (Final disease or condition resulting in death) a. Emphy						15 Years
	xaminer			or as a consequence of):					
pe	sit	iner	if any, leading to immediate cause. Enter Underlying	or as a consequence of):					
J, execut	n and ial-tran	Examiner	that initiated events resulting in death) Last C. Due to	or as a consequence of):					
68/60 , tificate be executed	physician and s the burial-transit	edical	d						
X O	, Ö. 4	ian/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, out	come of pregnancy				23d. Date of del	iverv
Hecords, P.O. Box	ed by the attendin detached for use	Physiciar	in the past 12 months?	ant at time of death 5	□Ectopic pregna <i>ncy</i> □ Other (specify)			Month	Day Year
S, T	igned b	by Pt	Part II. Other significant conditions contributing to de	-	underlying cause giver	in Part I.		acco use contribute to	
	been si		Osteoporosis with Ch	ronic Pain	·				obably 4 Unknown
I HECOLOS, The law requires t	ate has b	Completed					24a. Was ar autops perform	y prior to ned? death?	Itopsy findings available completion of cause of 2 No
OT VITAL	certificate rector, pag	Be	25. Was case referred to medical examiner?		Other		th (Check only on		
öå	rthis raldi	n: To	27. Manner of Death 28a. Date		of 28c. Injury	at Norsing Fit		nce 6 Other (Spe w injury occurred	cify)
VISION	death. ctor: After y the funer	atio	2 Accident investigation	th, Day Year) Injury		es 2□No			
DIVISION Attending	within 24 hours after death	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place buildi	of Injury - At home, farm, s ng, etc. (Specify)	treet, factory, office		28f. Location (St. City or Town	reet and Number or Ri , State)	ural Route Number,
UI.	24 hour	edical	29a. Certifier 1 Certifying Physician: To the (Check only one)	best of my knowledge, dea asis of examination and/or i ner stated.	ath occurred at the time investigation, in my opi	e, date and place, nion, death occur	and due to the cared at the time, da	tuse(s) and manner as ate and place, and due	stated. to the cause(s)
To the	within To the	Me	29b. Signature and title of certaier		29c. License	number	29	9d. Date signed (Mont	
k	2+1		(ill) Deboo	lien	D265	540		July 18,	
`			30. Name and address of person who completed cause Carl Schoenberger, M.		ederick Rd	. Suite		thersburg,	Maryland 20877
	Sta Registi			Indiatrada Cignotura	arti				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear Month **Physician** 04:50 A M JAMES KIRBY HILL JULY 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FAIRFIELD NURSING CENTER ANNE ARUNDEL CROWNSVILLE If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 XM 2 F 76 Director 029-20-7072 12/17/1928 MASSACHUSETTS Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 28a-f ehow 1 and 2 should be filed within 72 hours after death with the Marylar Heatilb and Mental Hygiene.
em 27 is marked other then "naturat", or items 23s or 28s-1 ehow that fraumatic event, it is Madical Examine must be natilitad as 1 ☐ Yes 2 No Director MD QUEEN ANNE'S **QUEENSTOWN** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 217 OLDE POINT LANE 21658 by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 WYes 2 No If Yes, Give Year or Dates: 1949— 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 ☐ Never Married 2 📉 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗙 No Specify. Specify: WHTTE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 ANALYST US GOVERNMENT- NSA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GEORGE HILL MARGARET MULLINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ELLEN DELORES HILL/WIFE 217 OLDE POINT LANE QUEENSTOWN, MD 21658 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State VETERANS Department of important: If any injury or injury or * 4 ☐ Donation 5 ☐ Other (Specify) 07/14/2005 CROWNSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD CHESTER, MD 21619 Murey 23a. Part1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each inc. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician alle /Medical Du to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth / 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No been signed be should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, p 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 1 Tes 1 Yes 2 No 2 X No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie MD impleted cause of death (Item 23a) (Type, Print) Olin Barnie MD 21061 208 Jinga 100 31. Date tiled (Month, 32. Re State 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 10, Physician 2005 16:45 HIGGS WILLIAM **JENNINGS** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner University Hospital-Shock Trauma Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. JULY 19, 1920 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M M 2 □ F VIRGINIA Yrs. 218-05-6514 Director 84 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "naturel", or items 23a or 28a-1 show other traumstic event, the Modical Examinationals be notified at 1 Yes 2 No HENDERSON CAROLINE MD Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21640 221 COX SAWMILL ROAD Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? filed within 72 hours after 1 XYes 2 No If Yes, Give 1944-1946 Year or Dates: 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **FARMING FARMER** 9 -0and Mental Hygie is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be MAMIE HINTON BENJAMIN HIGGS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 441 COX SAWMILL ROAD, HENDERSON, MD 21640 EUGENE HIGGS/ SON 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 XBurial 2 □ Cremation 3 □ Removal from State ŏ 7-15-2005 SUDLERSVILLE, MD artment ortant; I injury c SUDLERSVILLE CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) permit.
Departn
Imports
any inju 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MultiPl e 14 Physician /Medical Due to (or as a consequence ou Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No 24a. Was an hes le 2 autopsy performed Yes 2□No ; After this certifica e funeral director, § Be 25. Was case referred to medicat 26. Place of Death (Check only one) Hospital: 1 Inpatient ပ္ 1XYes 2 No 2XER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification: passenger ingural in moter vehicle 1 Natural 5 Pending s after death. Il Director; Aft ed in by the fun 15:40 7/10/05 2 Accident 3 Suicide investigation 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) Route 301 of Rural 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) SCY (extre ville 1MD) 21617 4 Homicide rest 57 within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

11 2 2000

LOR 30. Name and address of person who completed cause of death (Item 23a) (Typg_Print)

32. Registrar's Signature

ENN. STREET., BALTIMORE,

OCME

July 11, 2005

			For State Registrar				nd / Depa Cea		t of H	ealth a		•	/giene	200		335
,	Physici /Medio Examin	ai	Decedent's Name (First, Mix Marlee Marlee 4a. Facility Name (If not institute)	n C.	reet and numi	ber)				Location of	of Death	2. Date of Do Month	Day 4 2 3	County of D	0.5 03: eath	f Death
	Funeral Director		Mallard Ba 5. Social Security Number 213-36-6247	6. Sex	<u>~</u>	. Age (In yrs.	last birthday) 68 Yrs.	If Under Months	1 Year	dge If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D Jan . 24			lester Birthplace (State Country) aryland	or Foreign
	e Maryland 8a-f show	ctor		rche	ster	10c. Ci	ty, Town or Lo	lesda	ıle						10d. Inside C	ity Limits
	3s or 2	al Dire	10e. Street and Number 5132 Rhodes	dale	-Vieni	na Roa	ad	10f. Zip		659			_	ted S	Country?	
9036	within 72 hours after death with the Maryland jiene. r than "natural", or Items 23a or 28a-f show La Medical Examinat must be notified at	d by Funeral Director	11. Marital Status 1 Never Married 2 M M 3 Widowed 4 Divorce	arried	2. Was Deced Armed Ford 1 ☐ Yes 2 If Yes, Give Year or Dat	es? 2 XNo		Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:	gin? (Spe i, Puerto	ecify Yes or N Rican, etc.)		Black, W	merican Indian, /hite, etc. White	
Maryland 21215-0036	J within jiene. r than	Completed	(Specify only hig Elementary/Secondary (0-12 12)		4or 5+)	lite.	dent's Usua kind of wor DO NOT us	e retired	ts I	nst	ructoi	Edu	nd of Busine		E
land	e d la b	To Be	17. Father's Name (First, Midd Cleveland		neal							<i>(First, Middle</i> Carnea		Sumame)		
Mary	s 1 and 2 should i Health and Men item 27 is merke other traumettc		19a. Informant's Name/Relation			Snoue	19b. Mailir	ng Address	(Street a	nd Numbe	or or Rura	I Route Numb	oer, City or	Town, State	e, Zip Code 216	559
Baltimore, I	00		20a. Method of Disposition 1 X Burial 2 Crematic 4 Donation 5 Other	n 3 □Re		20b. F	Place of Dispo	sition (Nan matory or o	e of ther place	9)	C	Date	20c. Loc	cation - City	or Town, State , Maryl	
Balt	permit. Pag Department Important: I sny Injury o		21. Signature of Funeral Servi	ce Licensee	Con	lo.	22	2. Name an	d Addres	s of Facilit ain	y Fra St.	ampton , Fede	Fur erals	neral	Home, , MD 21	P.A.
	Physician		23a. Part1. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)	or complicist only one	ations that can cause on ear	used the deat ch line.								Juli 8	Approximal Interval Bet Onset and 5 mu	te tween Death
A .	/Medical Examiner	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	 b.	C020	ras a consecutive ras a consecutive	Art	27		SCHS	01				740	m
,092	ite be executed ysician and he burial-transit	ical Examin	Cause (Disease or injury that initiated events resulting in death) Last	c.	Due to (or Ewa	rasa conseq l S A	ecl t quence of):	Polm ling	/	lise		2056	\$		34- 6m	13
.O. Box 68	that the death certificate bed by the attending physic detached for use as the b	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23		th 2 ☐ Feta nt at time of c	al death 3	Ectopic pro					2	3d. Date of Month	,	Year
٥.	w requires that the been signed by th should be detache	by	Part II. Other significant cond DiASetes			th but not res	sulting in the u	nderlying ca	iuse give	on in Part I.			tobacco us		e to the cause of o	
of Vital Records,	The law ate has t page 2 s	Completed	ANTI tho	mbo	in 1	H d	efects	ve J				24a. Was auto perf 1 \(\text{Yes}	s an psy ormed? 2010			
r Vit	Physician: The this certificate ral director, pag	o Be	25. Was case referred to med examiner? 1 ☐ Yes 2 ☐ No		spital: 1 🗆 Ing	patient 2] ER/Outpatien	it 3 DO	A Othe	P		ne 5 ☐ Res		□Other (S	pecify)	
Division of	ing After une	ertification; T	Z [] / tooldont	stigation		, Day Year)	28b. Time of Injury	М		11.00	No	28d. Describe	how injury	occurred		
DİVİ	ial or Attend s after death al Director: ,	Certifi		mined	28e. Place o building	of Injury - At h g, etc. <i>(Specil</i>	ome, farm, str fy)	eet, factory	, office		1	28f. Location (City or To	(Street and wn, State)	i Number or	Rural Route Num	iber,
	ne Hospital or An 24 hours after he Funeral Dire	edical (29a. Certifier (Check only one) Cartif	ying Physi al Examine	cian: To the b er: On the bas and manne	is of examina	owledge, death ation and/or in-	n occurred a vestigation,	at the tim in my op	e, date an	d place, a	and due to the ed at the time,	cause(s) a date and	and manner place, and c	as stated. due to the cause(s	;)
	To the I within 2. To the Complet	¥	29b. Signature and title of cert	Eck	lu	-		1		number	88			_	onth, Day, Year)	5
_			30. Name and address of pers MICHAEL	TF	Aclobe	n me	п 23a) (Туре. 30)	Print)	lin	c We	- 1	Herro	chi	nel	2643	?
	Sta Registr		31. Date filed (Month, Day, Ye		0	gistrar's Signa	ature			,						
DH	MH 17 Rev 1/2	001	THE LA	~~~	1000		1	TO THE REAL PROPERTY.								

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 16 2005 Carl Edward Hall July 0930 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 25,1931 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2□ F 246-36-2074 74 Yrs. North Carolina **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show 1 ☐ Yes 2X No Directo Maryland Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 934 Ebenezer Church Road U.S.A. 21911 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: 1949-54 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hopewell Cemetery Elementary/Secondary (0-12) College (1-4or 5+) Port Deposit, Maryland Six Years Caretaker other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental F Is marked of James Monroe Hall Ludema Wyrick 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is m any Injury or other treum 2008. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret C. Hall 934 Ebenezer Church Road, Rising Sun, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Hopewell Cemetery 07/21/05 Port Deposit, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) lalive Pnysician /Medical Due to (or as consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner P.O. Box 68760, resulting in death) Last Due to (or as a consequence of Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? phillip LT, 24a. Was an this certificate has autopsy performed? Yes 2014 entension 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 ☑ No Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Mann Death

1 atural

Accident 28b. Time of 28d. Describe how injury occurred Director: After 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) n who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

Registrar

24636204

			For State	State of M	aryland /				Mental H	ygiene	Э	
			Registrar			Centiti	cate of	Death	2. Date of D	Reg. No	2005	2-5-3-3-7
-	Physici	an	1. Decedent's Name (First, Middle, La	,					Month	Da	Year 2005	0600 M
	/Medic	al	Julius Joseph Ho 4a. Facility Name (If not institution, giv			4h	City Town o	or Location of Deat	Juli	} 	County of Death	
	Examin	ier	UNION H	OS PITA	L		ELK	KTON			CECIL	
	Funeral		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Sex 7. Ag	ge (In yrs. last bi	Mo	Inder 1 Year nths Days	Hours Min.	(Month, E	ay, Year)	Cou	place (State or Foreign ntry)
	Director		003-12-4672 Usual Residence of Decedent	A. 201	79	Yrs.			Sept.7	, 1925	Rhode	Island
	and		10a. State 10b. County		10c. City, Tov	wn or Locatio	n					10d. Inside City Limits
	Marylan -f show ied at	ō	Maryland Cecil		Elktor	1						1 ☐ Yes 2 🛣 No
	death with the Maryland me 23a or 28a-f show rmust be multited ut	Director	10e. Street and Number		LIKCOI		of. Zip Code			10g. Ci	tizen of What Cou	ntry?
	3a ol		54 Woods Way				21921			Unit	ed State	es
	deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. Was	Decedent of h	Hispanic Origin? (S	Specify Yes or N	10-	14. Race - Ameri Black, White,	
9	after or ite	F	1 Never Married Married	1 ☐ Yes 2X If Yes, Give			es 2X No		, , , , , , , , , , , , , , , , , , , ,		Specify: Whi	
000	uraf',	d by	3 Widowed 4 Divorced	Year or Dates:	100	- D + - #				105 11		
15-	nati edice	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	162	Give kind: ife. DO N	Usual Occup of work done OT use retire	pation during most of wo id)	rking	165. 8	(ind of Business/Ir	idustry
12	withii ene. than	m d	Elementary/Secondary (0-12)	College (1-4or				ultant		Pov	ver Compa	inv
d 2	filed Hygi Sther		17. Father's Name (First, Middle, Last		1 11	пртоус	c cons	18. Mother's Na	me (First, Middl			
an	lid be lental ked c	To Be	Julius Joseph Ho	fmann				Lillian	Whitak	er		
Maryland 21215-0036	shou and M a mar umat	_	19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailing Ad	dress (Street	and Number or R	ural Route Num	ber, City	or Town, State, Zij	Code)
Ž	adith a		Mary Hofmann/Wif	e	54	4 Wood	s Way,	Elkton,Ma	aryland	2192	21	
3altimore.	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiens to Marylai Inforcent: It item 23a or 28a-1 show any njury or other treumstic event, It a Medical Examinar must be notified at 2006.		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of cernete	of Disposition ery, cremator	(Name of y or other pla Concep	ςe). July	y 23,	20c. L	ocation - City or T	own, State
Ë	Pag nent ent: It		`4 □Donation 5 □Other (Speci		Immacu	Ceme	tery	200	05		on, Mary]	and
<u>~</u>	permit. Departr Importu any inju		21. Si l'ature o Funeral Se di Lige					ess of Facility C:				
	20599			MOOS							ıst,Maryl	and 21901
- 1			23a. Part1 Enter the disease, or con shock, or heart failure. List only	one cause on each li	ine.	not enter th	e mode of dyl	ng, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	PSIS							10 days
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	(10 e)	Α.					10 days
SEPH 0. *		-	Sequentially list conditions, if any, leading to immediate	b	a consequence	a of)·		81				0
113	bet Insit	i	Cause (Disease or injury	CH	RONIC	R	ENA	L FAIL	URE	,		1 Month
S	execunand nandial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence							
20.5	cate be executed physician and the burial-transit	dical		d								
1 89	tifical ng phy as th	led										
) ŏ	The law requires that the death certificate be executed to has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth	of pregnancy 2 Detail deat	th 3⊟Ecto	pic pregnanc	v			23d. Date of deliv	,
~ C	e deal	sicia	in the past 12 months? 1 Yes 2 No	4☐Pregnant a 9☐Unknown			er (specify) _				Month	Day Year
-> 0	that the de led by the a detached f	Phy	9 Unknown			:- th		one in Cont.	23a Did	tobacco	use contribute to	he cause of death?
HOFMANN on of vital Becords.	ires tha signed	by	Part II, Other significant conditions	contributing to death t	out not resulting	in the under	ying cause gr	venin raiti.		Yes 2		bably 4 Dunknown
Z	w requires been sign should be	eted										
FMANN Vital Becords	has b	Completed							24a. Wa aut	s an opsy formed?	prior to co	opsy findings available empletion of cause of
$\sum \frac{\pi}{n}$				1					1 Tes	2 1 No		2 □ No
خ للا		o Be	25. Was case referred to medical examiner?	Hospital:			Ott	26. Place of De her: 4 \subseteq Nursing i	ath (Check only		0 (304) (2	4.1
0 7	Phys r this gral di	\vdash	1 Yes 2 No 27. Manner of Death	1 Inpati 28a. Date of Inju	urv 28b.	. Time of	28c. Inju	ry at	28d. Describe			ry)
工品	tending Phy death. for: After thi the funeral of	tlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigate	(Month, Da	ay Year)	Injury I	Wo	ark?]Yes 2∐No				
Division	or Attending after death. Director: After in by the fune	Ifica	3 ☐ Suicide 6 ☐ Could not I	280. Place of th	jury - At home, f	farm, street,	actory, office				nd Number or Rur	al Route Number,
, id	al or	Certification:	4 Homicide	building, e	tc. (Specify)				City or 1	own, Stat	B)	
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the	edical ((Check only 2 Medical Exa	hysician: To the best miner: On the basis of	of examination a							
	thin 2 the the	Med	one) 29b. Signature and title of Pertifiers	and manner st			29c. Licens	se number		29d. Da	ate signed (Month,	Dav. Year)
	N T W		Alarlinh	K IVID			D50	7398		JU	Dy 19	, 2005
	0		30. Name and address of person who	completed cause of	death (Item 23a)) (Type, Prin)	A :			0	0111 0 110
	10		30. Name and address of person who ALOK RUSTOG 31. Date filed (Month, Day, Year)	1, MD	, UN	ION	HUSP	MAL,	ELK.	TON	, MA	KYCHND.
		atė	31. Date filed (Month, Day, Year)	32. Regist	rarls Signatur	whe		· · ·				
	Regist	rar	JUL 2 1 2005	MANUEL -	~ 7							

			1 - For State Registrar		State of M	/larylan		artmen rtificat					Reg. No	00-	5 25	220
	Physici	an	1. Decedent's Nam	Ethel								2. Date of De Month	Da		36-Timel of 12:55E	Death ()
	/Medio		<u>-</u> _		ve street and number	r)		4b. City,	Town, or	Location		July 1	15,	2005 County of De		
	LXamii	161	-	Maryland H				Clint	on on				P	rince Œ	eorge's	
	Funeral Director		5. Social Security N 230-22 Usual Residence of	-0742	Sex 7./ 1 ☐ M 2 🛣 F	99	last birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da March 19	th y, Year) 190		Birthplace (State of Country) Th Carolin	
	ow ow		10a. State	10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside C	ity Limits
	Many a-f sh	tor	MD	Prince G	eorge's	For	rt Washi	ngtan							1 ½ ∑Yes	2 □ No
	or 28)jre	10e. Street and Nu	mber				10f. Zip						izen of What	Country?	
	s 23e	ral		terly Lane	10 Mac Dagada	t Cues in II	6 47	207		innania Ori	i=i=2 (C=	aif. Van an Na	U.		merican Indian,	
215-0036	72 hours after death with the Maryland neturel', or ltems 23e or 28e-f show dical Examiner must be nuffised at	by Funeral Director	11. Marital Status1 ☐ Never Marital3 ☐ Widowed	ried 2 Married	12. Was Deceder Armed Force: 1 Yes 2 If Yes, Give Year or Dates	s? } No		was Decei If Yes, spe- 1 Yes				ecify Yes or No Rican, etc.)	,	Black, W SpecifyBla	hite, etc.	
2-0	72 ho netur	eted	(Sne	15. Decedent's &	ducation		16a. Dece	dent's Usua	al Occupa	ation	t of worki	na	16b. K	ind of Busine	ss/Industry	
21	nithin ne. han "	Completed	Elementary/Sec		College (1-40	r 5+)	Diet	kind of wo DO NOT u ician	se retired	1)			Pr	ivate		
Maryland 21	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Experiment must be nutilised at once.	To Be Co	17. Father's Name	(First, Middle, Las								(First, Middle,				
ary	shou and M s mar	-	19a. Informant's N	lame/Relationship	(Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rura	I Route Numbe	er, City o	or Town, State	a. Zip Code)	
	and 2 ealth a n 27 I		Debora	h R. Hi	cks-Nied		_)			ly L					, MD 20	0744
Baltimore,	ges 1 t of Hi If iter or oth		20a. Method of Dis 1 Burial 2		☐Removal from Stat		Place of Dispo emetery, crei evelt M	matory or c	ther plac	e)	7–22-	OS			or Town, State Virginia	
Iţi I	it. Pa rtmen rtant: njury			5 ☐ Other (Speciuneral Service Liga		ru				i						
Ba	Depariment Deparement of the police once.		21. Signatura of F	alma /	1 8	o DO						recte & A	ASSOC	. Furera	al Home In	C .
	W 1897 1		23a. Part1. Enta	the disease, or cor	mplications that caus y one cause on each	ed the deat							rrest,		Approximat Interval Bet	.6
	Physician		Immediate Cause	(Final	y one cause on each	octr	121	m 1	n Pa	Tine	06	Colo	n)		Onset and I	Death
	/Medical Examiner		resulting in death)		Due to (or a	as a conseq			1110	CLUVI						
	Lxammer	<u></u>	Sequentially list co	onditions,	b. Due to (or	s conseq	S of the second									-
	nted Insit	Examiner	Sequentially list co if any, leading to in cause. Enter Und Cause (Disease o	erlying r injury	Due 10 (01 a	sa conseq	derice oi).									
Ć	cate be executed physician and the burial-transit	Exal	that initiated event resulting in death)	(S	Due to (or a	as a conseq	uence of):									
8760,	ite be iysicia ne bur	dical		•	d								_			
9	artifica ing ph e as th	Med	IF FEMALE:													
O. Box	he death certific, the attending pl ched for use as t	Physician/Med	23b. Was deceded in the past 12 1 Yes 2 9 Unknown	2 months?	23c. If yes, outcon 1□Live birth 4□Pregnant 9□Unknown	2 Feta at time of d	Ideath 3[]Ectopic pi] Other (sp						23d. Date of o Month	,	Year
Δ.	law requires that the de as been signed by the 2 should be detached		Part II. Other sign.	ificant conditions	contributing to death	but not res	ulting in the u	nderlying o	ause give	en in Part I	l.	23e. Did t	obacco t	use contribute	to the cause of d	leath?
Vital Records,	quires in sigr uld be	Completed by	rev	ral fail	ure							1 🗆 '	Yes 2	X No 3□	Probably 4 □	Jnknown
000	8 8	plet		•								24a. Was		24b. Were	autopsy findings to completion of c	available
B	The lav ate has page 2	E O										perfo	rmed? 2 No	death	?	8036 01
/ita	Physicien: The this certificate ral director, pag	Be (25. Was case refe examiner?	rred to medical	Haitali				0.1		e of Death	(Check only o	ne)			
of	Physi this c	2	1 Yes 25	No	Hospital: 1 Inpa		ER/Outpatier 28b. Time o			4 L NU		me 5 🗌 Resid			pecify)	
ono	ding F h. After funer	tlon	1 Natural 2 Accident	5 Pending investigate	(Month, L	Day Year)	Injury	' м ²	28c. Injury Work 1 □ `	γαι k? Yes 2□		zou. Describe i	now inju	y occurred		
Division	ol or Attending after death. I Director: After d in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not	be 28e. Place of	njury - At ho etc. (Specif	ome, farm, str	reet, factor	y, office			28f. Location (S City or Tox			Rural Route Num	ıber,
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier (Check only one)		Physician: To the beaminer: On the basis and manner	of examina										;)
	With Tot	Σ	29b. Signature and	d title of certifier	1.			290	. License	number	201	20	29d. Da	te signed (Mo	onth, Day, Year)	
	111/2		•	4. 44as	run'ay	<u></u>			ν	05,	240	14		7/16	15	
	44/1		AliRo	whimio	completed cause o	150	1 read	Print)	Rd	Su	11to	205	5,0	linto	mmd	2073
	Sta	ate	31, Date filed (Mo	nth, Day, Year)	32. Regi:	strar's Signa	Boool	-								

Sean Horton 05-04719 RPD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For Stata Ragistrai Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 July 12, **Physician** Sean Patrick Horton 2120 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Bowie Health Center Bowie Prince George's If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth
(Month, Day, Year)
July 22,1988 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 218-29-4315 16 Director Annapolis, MD Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at MD Prince Georges Bowie 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 4507 Orangewood Lane 238 20715 Funeral U<u>SA</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. within 72 hours after 1 Never Married 2 ☐ Married ŏ 3altimore, Maryland 21215-0036 1 Yes 2 No þ Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Student Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fament of Health and Mental Part: If Item 27 is marked of William Francis Horton Carol A. Jones -Horton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William F. Horton/ Father 4507 Orangewood Lane Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. Huntt Crematory 4 ☐ Donation 5 ☐ Other (Specify) 7/14/2005 Waldorf, MD 21. Signature of Fuperal Service Licenses 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit certificate be executed Examl Due to (or as a consequence of) Box 68760, Physiclan/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a ld be detached fo P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 00 Completed 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? certificate 1 X es 1 Yes 2□ No Division of Vital 2 🗆 No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 2 Yes 2 □ No 1 🗌 Inpatient 2 ER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After thi funeral 28b. Time of Lour 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural ubject nanged 1 ☐ Yes 2 Xo death. М within 24 hours after death To the Funeral Director: / completely filled in by the f 2.□ Accident 6 Could not be determined 3 Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number ō 5000 ucod Lane □ Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier and manner stated 29c. License number OCME 29b. Signatu 29d. Date signed (Month, Day, Year) July 13, 2005 Path (Nem 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NUL 1 5 2005 Registrar

				of Maryland / De	epartment of Health and N	-	•
			Registrar		Certificate of Death	Reg. f	<u>2005 25340 </u>
	♥ Physici /Medic		1. Decedent's Name (First, Middle, Last) Q V TH	HUSTE	AD	2. Date of Death Month	Day Year 3. Time of Death
	Examir	er	4a. Facility Name (If not institution, give street and no		4b. City, Town, or Location of Death		c. County of Death
			FOREST HAVEN NU 5. Social Security Number 6. Sex	7. Age (In yrs. last birtho			9 Birtholago (State or Foreign
	Funeral Director		218-80-6292 Usual Residence of Decedent	87 Yrs	Months Days Hours Min	8. Date of Birth (Month, Day, Yea NOV . 14,	9. Birthplace (State or Foreign Country) 1917 Maryland
	dand ow		10a. State 10b. County	10c. City, Town o			10d. Inside City Limits
1	the Mary 28a-f sh offined	ector	MD Baltimore		Catonsville	100	1 Tyes 2 No Citizen of What Country?
L	with ta or	Dir	701 Edmondson Ave.		21228	, og. (USA
3	leath ms 23	era	11 Marital Status 12. Was Dec	cedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show important: If item 27 is marked other than "attural", or Items 23a or 28a-f show yinjury or other traumatic event, The Medical Examiner must be notified at once.	Completed by Funeral Director	Armed F	2 No ive	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	Rican, etc.)	Black, White, etc. Specify: white
21215-0036	in 72 ho n natura	pieted	15. Decedent's Education (Specify only highest grade completed) (C	ecedent's Usual Occupation Give kind of work done during most of work fe. DO NOT use retired)	ing 16b.	Kind of Business/Industry
212	filed withi Hygiene. other than	mo	Elementary/Secondary (0-12) College	(1-4or 5+)	homemaker		own home
and	ould be filed Mental Hygis terked other latic evant, I	To Be C	17. Father's Name (First, Middle, Last) Edwin Bosworth			e (First, Middle, Maid la Jeffrey	en Sumame)
Maryland	d 2 should th and Men 7 is marke traumatic	_	19a. Informant's Name/Relationship (Type, Print) Edwin Hustead	1	Hailing Address (Street and Number or Rur B S. Union St., Alex	-	
	permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other tra once.	1 3	20a. Method of Disposition				Location - City or Town, State
nor	ages ant of t: If it		1 ⊠Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	Julie	crematory or other place) ter Memorial Park 7,		ambridge, MD
Baltimore,	nit. Partme artme ortan injur		21. Signature of Funeral Service Licensee	porches			ral Home P.A.
B	Departiment Department		Barrie K. Burre		700 Locust St., Car		
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do not			Approximate Interval Between
	Prrysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Dt	EMENTIA		Onset and Death
	Examiner			(or as a consequence of)	:		
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	(or as a consequence of)	:		
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events c.				
760,	e exe ian a urial-t	Ex	resulting in death) Last Due to	(or as a consequence of)	:		
876	ys se	licai	d				
O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit.	Physician/Med	in the past 12 months?	utcome of pregnancy birth 2 ☐ Fetal death nant at time of death	3 Dectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
P.O.	that the	Ph	Part II. Other significant conditions contributing to	death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
Records,	w requires been signe should be	ted by				1 □ Yes	2 No 3 Probably 4 Phknown
Rec	aician: The law i certificate has bu irector, page 2 sh	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2₽₩₩
Vital	yaician: is certifica director, I	Be	25. Was case referred to medical examiner?			h (Check only one)	
of V	w (1) 71	To	1 ☐ Yes 2 PNo Hospital: 1 ☐	Inpatient 2 ER/Outpa		me 5 Residence	
n	ng ffei	on:		of Injury 28b. Timenth, Day Year) 100	iry Work?	28d. Describe how in	jury occurred
Sic	Attanding r death.	icat	2 Accident investigation 3 Suicide 6 Could not be	e of Injury - At home, farm	M 1 Tyes 2 No	28f Location /Street	and Number or Rural Route Number,
Division	safter or All safter of al Dirac	Certification:	determined 200. I lau	g of injury - At home, farm ding, etc. (Specify)	, street, ractory, omce	City or Town, Sta	
	To the Hospital or Attandi within 24 hours after death. To the Funaral Diractor; A completely filled in by the fu	Medical	(Check only 2 Medical Examiner: On the	e best of my knowledge, obasis of examination and/onner stated.	death occurred at the time, date and place, or investigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	, 0 0	29c. License number		Date signed (Month, Day, Year)
			/ Ca	m JU)	D373	SS Ju	14 15, 2005
			30. Name and address of person who completed cat	ise of death (Item 23a) (Ty	/pe, Print)	102113	3
	Sta Regist		31. Date filed (Month, Day, Year) JUL 1 9 2005	Registrar's Signature	Care of		
			30F - 4 5003	BRAGO AS			

		1 - State Unpend Item 2		Marylan I,27,2 8	d/Depa Ba-f _{Ce}	ertment of ler me G84 rtificate of	lealth a 6 8-1 Death				05	2534
Physici	an	1. Decedent's Name (First, Middle, Las Audrey Isb	e11						Date of Dea Month July	-	2Ŏ Ů 5	3. Time of Death 03:30 A
/Medic Examin		4a. Facility Name (If not institution, give	street and num			4b. City, Town, Cla	r Location o	of Death	, all	4c. County Howa	of Death	03.30 1
, Funeral Director		2,7 20 7033	ex □ M 2□F	7. Age (In yrs. 1	/ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day July 8	r, Year)	9. Birthpl Count Virg	
death with the Maryland me 23a or 28e-f show Laust be notified at	ž	Usual Residence of Decedent 10a. State 10b. County MD Howard			y, Town or Lo						10	0d. Inside City Limi
the M	ecto	MD Howard 10e. Street and Number		CI	arksvi	.11e				10g. Citizen of V	What Count	
with Ba or	2	13135 Triadelphia	Mill Ro	oad		21029				USA	VIII 000	.,,.
urs after death	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	es? 2 🔯 No		Was Decedent of H f Yes, specify Cub	fispanic Orig an, Mexican Specify:	gin? (Specif , Puerto Ric	ly Yes or No- can, etc.)	14. Raci Blac	e - America k, White, e White	itc.
thin 72 ho e. "natur Madical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-	4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most d)			16b. Kind of Bu		,
of 2 should be filed within 72 hours aft thand Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exp. of	Con	12			Sta	tistical				US Gov		ent
buld be fit Mental H arked oth atic even	To Be	17. Father's Name (First, Middle, Last) Alpheus G. Thor					Agr	nes Da	ivis	Maiden Sumam		
permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygiene. Importent: if item 27 is marked other than "natural", or iteme 23a or 28e-f ahov any injury or other traumatic event, the Madical Examinational be notified at SIRE.		19a. Informant's Name/Relationship (7 Nora Mae Maclaugh 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	lin/Daug	20b. P	13135 lace of Dispo	Triadel sition (Name of natory or other place Church	phia M	Iill R Date	d. Cla		e, MI City or Tov	21029 vn, State
Departm Importe any inju		21. Signature of Feneral Service Licen)		. Name and Addre			-Rinal	di Fune	ral H	lome, Inc.
Physician / Medical Examiner physicien and physicien and the private ither private ithe private ithe private ithe private ithe private ither privat	dical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (o	r as a consequ r as a consequ r as a consequ	uence of):	plicatin	g Ciles	st III	iur y			
The law requires thet the death certificate has been signed by the attending ploage 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Ø No 9 □ Unknown		h 2 □ Fetal nt at time of de	death 3 [Ectopic pregnancy Other (specify)	,			23d. Date Mor	e of deliver	y Day Year
juires thet signed b	d by Pr	Part II. Other significant conditions co Hypertensive ather	-		-				23e. Did tob			cause of death?
The law require has been age 2 shoul	E	Chronic obstructiv		nary di	sease;	Diabetes	melli	tus;	24a. Was a autops perform	n 24b. W	Vere autoportion to comeath?	sy findings availab
dertifice rector, p	To Be C	Fractured right an 25. Was case referred to medicat examiner? 1 ☑ Yes 2 □ No	Hogostal:	patient 2 🗆 E	ER/Outpatient	3□ DOA Oth	er. 4 Nur		neck only on			
fte fte	Certification: 1	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of (Month, 6-24-0) 28e. Place of)5		M 28c. Injun Wor M 1 —	yat k? Yes 2 🛣 N	280 Su	. Describe ho bject	w injury occurre Fe11	əd	Route Number
nerei Dir	al Cert	29a. Certifier 1 ☐ Certifying Phy	Reside	ence est of my know	vledge, death	occurred at the tir	ne, date and	Mi place, and	11 Roa	d Clark	svill	e, Maryl
To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	(Check only one) 29b. Signature and title of Centifier	ner: On the bas and manne	is of examinati	on and/or inv	estigation, in my o	pinion, death	h occurred	at the time, da	ate and place, a 9d. Date signed July 24	nd due to t	he cause(s) ey, Year)
		30. Name and address of Jerson who co	ompleted cause	of death (Item	23a) (Type, F	Print)		reet				nd 21201
State	e	31. Date filed (Month, Day, Year)	32. 199	istrar's Signatu	Jure A	arke			202011			21201

			1- For State Registrar Amend Item	State of Maryla						5 2	5342
ľ	Division		Decedent's Name (First, Middle, Last,		074 470	4700 on.		2. Date of Death	1		3. Time of Death
	Physic /Medi		ANNA JOin					Month July	17	^{Year} 2005	11:1 ^A
7	Exami	ner	4a. Facility Name (If not institution, give				Location of Death		4c. County		
	Funeral		9503 Prince Wil 5. Social Security Number 6. Sec		s. last birthday)	Brandy			rince		ge's
	Director		099-09-0747	^{1M} X □ F 87	Yrs.	Months Days	Hours Min.	8. Date of 96 (Month, 9a), July 1	Year) 7 1918	Country)	York
	and		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	ncation					
	death with the Maryland ms 23s or 28e-f ehow	tor	Maryland Prince G		andywin					100.	Inside City Limits 1 ☐ Yes 2 No
	ith the or 28e	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	hat Country	?
	ath wi	rai	9503 Prince Willia	m Drive		20613			USA		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or items 23a or any injury or other treumatic event, it a Madical Examiner must be once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 27 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2√ No	ispanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black Specify:	- American K, White, etc. Whit	
2-0	72 ho	Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. Dece	dent's Usual Occupa	ation	1	6b. Kind of Bu	siness/Indus	try
121	within ine. ihan *	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of DO NOT use retired,)		O II-		
	filed v Hygie Sther 1	e Co	12 17. Father's Name (First, Middle, Last)		по	usewife	18. Mother's Name		Own Hor		
an	fental fental rked c	To B	Eugene Onody					ochmann		'/	
Maryland	and North		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	g Address (Street a				State, Zip Co	de)
	l and 3 lealth m 27 her tr		Gail Rooney (Daugh		9503	Prince W			dywine,	MD 2	0613
Baltimore,	in of H		20a. Method of Disposition 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1 □	emoval from State	-	natory or other place	9)		Oc. Location - (City or Town,	State
Iţi	artmer artent ortent injury		* 4 ☐ Donation * 5 ☐ Other (Specify) 21. Signature of uneral Service License			tan Crema . Name and Addres			1exandı		
Ba	permi Depar Impor any ir	, 6	Man H Eli	MO01	73 4	433 White	Pls. La.	erwein F White P	ls., MI	Servio 2069	ces 5
	Prysician /Medical		23a/hartl. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	A	wa	er the mode of dying		r respiratory arres	. 7	Inte	proximate erval Between aset and Death
	Examiner			Due to (or as a conse	equence of):					, ,	
	n =	ner	Sequentially list conditions, if any leading to introduct cause. Enter Underlying Cause (Disease or injury	Que to (or as a conse	quence of):					-	
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last								
8760,	be ex sician burial	aiE		Due to (or as a conse	quence or):						
687	ificate g phys	edicai	0							0.00	
O. Box	that the death certificed by the attending podetached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknow	ac. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	taldeath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date Mont	,	y Year
ords, P	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions con	tributing to death but not re	sulting in the un	derlying cause give	n in Part I.		cco use contrib		ause of death?
al Record	The ate h page	Completed						24a. Was an autopsy performe	nd2 de	ere autopsy to comple ath?	findings available etion of cause of
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital:	-	Othor	26. Place of Death				
of		\vdash	1 ☐ Yes 2 DNo	28a. Date of Injury	ER/Outpatient 28b. Time of	28c. Injury Work	4 🗀 Nursing Hon	ne Skriesidend 8d. escribe how			
ion	Attending is death. setor: After by the funer	atio	1 Natural 5 Pending investigation	(Month, Day Year)	Injury		? 'es 2 □ No		,,		
Division	- 9.5 7	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stre	et, factory, office	2	8f. Location (Stree City or Town,	et and Number State)	o <i>r Rural R</i> o	ute Number,
	To the Hospitel or within 24 hours af To the Funerel D completely filled in	edical	29a. Certifier (Check only one) Certifying Phys	ician: To the best of my kn er: On the basis of examin- pand manner stated.	owledge, death ation and/or inv	occurred at the time estigation, in my opi	e, date and place, a inion, death occurre	nd due to the caus d at the time, date	se(s) and manr a and place, an	er as stated d due to the	Cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. License	number	29d	. Date signed (Month, Day,	Year)
						DI	7431		1/19	10)
'n	10		30. Name and address of person who co	npleted cause of death (Ite	m 23a) (Type, F	Print)	NO A-11	XI.	A Louis	111	20341
17	Sta	e	3. Date filed (Month, Day, Year)	32. Registar's Sign	ature .	101/01	12 /	7//	UPIS NYA	7 M	00 179
	Registra	- 3	JUL 2 0 2		, K,	Spelle					

Jeffery Christi*a*n Edwin Johnson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05 - 4912State of Maryland / Department of Health and Mental Hygiene AKG 1- State Registrar Amended per Baltimore 28c. Certificate of Death 7/26/05 ASeg. No. 2005 2 Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2005 July 20, Jeffrey Christian Edwin Johnson **Physician** 15:45 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Federalsburg

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Month, Day,
Mar. 19, Woods behind 25390 Richardson Road Caroline 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Funeral 1 M 2 □ F 25 1980 Maryland 220-02-5475 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1 Yes 2 No Talbot Easton MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21601 West Street United States 109 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 Never Married 2 Married ☐Yes 2 No Specify: White Maryland 21215-0036 1 Yes 2 X No Specify 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Building Supplies Driver and Stock Clerk G.E.D. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mental Donnette Reynolds Newman Pages 1 and 2 should be John Elwood Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2207 King St., Lynchburg, VA 24501 f Health item 27 i Donnette Newman/Mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 0 1 ☐ Burial 2XX remation 3 ☐ Removal from State 07/22/05 Cambridge, MD Department of Important: if eny injury or once. Mid-Shore Cremation Ctr. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, 21. Signature of Funeral Service Licenses 216 N. Main St., Federalsburg, MD 21632 Coale 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval 8etween Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hausiss /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Be Completed by 1 ☐ Yes 2 🗷 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1√2 Yes 2 □ No 24a. Was an autopsy performed? certificate he lirector, page 1 X Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: $4 \square \text{Nursing Home} \quad 5 \square \text{ Residence} \quad 6 \ \square \text{Other} \text{ (Specify)} at \quad \text{SCene}$ 1 X Yes 2 ☐ No his 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 Natural 5 Pending Subject honged himself Found 14:57M death. 7/20/65 Tok res 2 No 2 Accident investigation after death Director: , I in by the f 6 ☐ Could not be 3 Suicide 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Woods 15390 Ridardson Rd, Federalsburg, hin 24 hours at the Funerat D mpletely filled i 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. *** Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

within 2
To the

State Registrar 31. Date filed (Month, Day, Year)

2 6 2005

111 Penn Street, Baltimore, Maryland 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

O.C.M.E.

July 21, 2005

		1	State	State of Maryland		irtment of He <i>tificate of E</i>			iene 	2531.1.
			Registrar 1. Decedent's Name (First, Middle, Last)			.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		2. Date of Deat	h	3. Time of Death
	Physicia		Ricky Jack	Jenkins				Month July	Day Year 19, 2005	7:30 AM M
	/Medic		Aa. Facility Name (If not institution, give s			4b. City, Town, or	Location of Deat		4c. County of Death	
	Examin	S.E.	St. Mary's Nursing			Leonard	town		St. Mary	,1 ,
	Funeral		5. Social Security Number 6. Sex		birthday)	tf Under 1 Year	If Under 24 Hrs			place (State or Foreign intry)
ь	Director		217-60-8678	M 2□F 52	2 Yrs.	Months Days	Hours Min.	Aug. 16	, 1952 Tenr	lessee
	P.	-	Usuet Residence of Decedent	10- Ch. T						10d. Inside City Limits
	arylar show		10a. State 10b. County	10c. City, T						1 ☐ Yes 2 ★No
	8a-1	Director	MD St. Mary's	s Mech	nanic	sville		1	Og. Citizen of What Cou	
	a or 2	吉	10e. Street and Number			10f. Zip Code 20659		"		intray:
	s 23	E -	40170 Beach Drive	2. Was Decedent Ever in U.S.	13 \	Was Decedent of His	snanic Origin? (5	Specify Yes or No-	U. S. A.	ican Indian.
	ter de Item	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	13.	f Yes, specify Cubar	n, Mexican, Puer	to Rican, etc.)	Black, White	
990	urs af		3 Widowed 4 Tolvorced	If Yes, Give Year or Dates:		I□Yes 2☑No	Specify:		Specify:	White
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23a or 28a-1 show ant, the Medical Exertificate the medified and	Completed	15. Decedent's Educ (Specify only highest grade		6a. Deced	dent's Usual Occupa kind of work done d	ition	rkina	16b. Kind of Business/l	ndustry
2	thin 7	nple.	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired)	, , , , , , , , , , , , , , , , , , , ,			
2	ed wi	S		1 0	Carpe	nter	40.44.0.1.41	me (First, Middle, M	Constructi	on
nd	be fill d off	Be	17. Father's Name (First, Middle, Last) William Jack Jenl	n					walden Sumame)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Exercitive from the notified at once.	2			40h Mailia	- Address /Street		ed Smith	, City or Town, State, Z	in Code)
Mar	12 sh h and 7 is n		19a. Informant's Name/Relationship (Type Mildred Carroll /	1					11e, Mary1a	
	1 and Healt em 2 ther 1	-	20a. Method of Disposition	20b. Place	e of Dispo	sition (Name of		Data	20c. Location - City or	
5	ages nt of :: If it		1 ☐ Burial 2XXCremation 3 ☐R	emoval from State		matory`or other place	1		C11	-11 MD
Baltimore,	it. Paurtment injury		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License			1d-Echo1s Name and Addres			<u>Charlotte H</u> Echols Funl	
Ba	perm Depa Impo any ir		Your Bat						lotte Hall,	
			23a. Part1. Enter the disease, or compli	cations that caused the death. I				 		Approximate Interval Between
	Pillian Marian		shock, or heart failure. List only or tmmediate Cause (Final	e cause on each line.		men la	W)			Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a cons squen	nce of):	SI	11/1			1 moners
Н	Examiner			Molin	ma	1	12la	nome	2_	wear.
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as consequit	ce of):					1
	cuted	Examine	that initiated events		1					1)
Ö,	ate be executed hysician and the burial-transit		resulting in death) Łast	Due to (or as a conseque	v e of):					
8760,		dicai								
9	death certifice e attending ph od for use as t	Me	IF FEMALE:	3c. If yes, outcome of pregnance	۸/				22d Date of deli	
Box	attend attend for us	hysician/Me	in the past 12 months?	1 Live birth 2 Fetat de	eath 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	Day Year
o.	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	0					
۳.		4	Part II. Other significant conditions cor	ntributing to death but not resulting	ng in the u	nderlying cause give	en in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
sp.	requires een sign hould be	d by						1 □ Ye	es 2No 3Pro	obably 4 Unknown
Record	> 40 00	Completed						24a. Was a		topsy findings available
Re	he e h e h	шс						autops perfori	med? death?	ompletion of cause of 2□ No
Vital	ian: T rificate stor, pa	0	25. Was case referred to medical				26. Place of De	eath (Check only on		
<u> </u>	Physician; this certific ral director,	To B	examiner? 1 ☐ Yes 2 No	lospital: 1 Inpatient 2 EF	VOutpatie	nt 3 DOA Othe	er. 4 Nursing	Home 5 ☐ Reside	ence 6 Other (Spec	sify)
o	ra fire		27. Manner of Death	28a. Date of Injury (Month, Day Year)	8b. Time o Injury	f 28c. Injury Work	/ at c?	28d. Describe ho	ow injury occurred	
	D D D	5								
	ending fath. br; After he funer	atlon	1 Natural 5 Pending 2 Accident investigation			M 1□'	Yes 2 □No			
	r Attender deatlinector:	rtiflcation		28e. Place of tnjury - At home building, etc. (Specify)	e, farm, st	M 1□'	Yes 2 □ No	28f. Location (Si City or Town	treet and Number or Ru n, State)	ral Route Number,
Division (r Attender deatlinector:	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Specify)		M 1 □ 1		City or Town	n, State)	
	r Attender deatlinector:		2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) 2 Medical Exami	building, etc. (Specify) sician: To the best of my knowle	edge, deat	M 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1	ne, date and plac	City or Town	n, State) ause(s) and manner as	stated.
	r Attender deatlinector:	Medical Certification	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 2 Accident investigation 6 Could not be determined	building, etc. (Specify) sician: To the best of my knowle	edge, deat	M 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1	ne, date and plac pinion, death occ	City or Town	n, State) ause(s) and manner as	stated. to the cause(s)
	or Attendifor death		2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) 2 Medical Exami	building, etc. (Specify) sician: To the best of my knowle	edge, deat	M 1 1 reet, factory, office the occurred at the time trestigation, in my of	ne, date and plac pinion, death occ	City or Town	n, State) ause(s) and manner as tate and place, and due	stated. to the cause(s)
	r Attender deatlinector:		2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of etifier Control of the control	building, etc. (Specify) sician: To the best of my knowle ner: On the basis of examination and mannel stated.	edge, deat	M 1 1 reet, factory, office the occurred at the time treatigation, in my of the control of the course of the cours	ne, date and plac pinion, death occ	City or Town	n, State) ause(s) and manner as tate and place, and due	stated. to the cause(s)
	r Attender deatlinector:		2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of detifier 30. Name and address of person who co	building, etc. (Specify) sician: To the best of my knowle ner: On the basis of examination and mannel stated. amplieted cause of death (Item 2	edge, deat n and/or in	M 1 1 reet, factory, office the occurred at the time extigation, in my of the control of the course of the occurred at the time extends of the course of the occurred at the time extends of the course of the occurred at the time extends of the occurred at the occurred at the time extends of the occurred at the occ	ne, date and plac pinion, death occ e number	City or Town	rause(s) and manner as late and place, and due	stated. to the cause(s)
	r Attender deatlinector:	Medical	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of etifier 30. Name and address of person who con James P. Jarboe, 31. Date filed (Month, Day Y8ar)	building, etc. (Specify) sician: To the best of my knowle ner: On the basis of examination and mannel stated. amplieted cause of death (Item 2	edge, deat n and/or in 3a) (Type,	M 1 1 reet, factory, office th occurred at the time vestigation, in my of 29c. License Print)	ne, date and plac pinion, death occ e number	City or Town	n, State) ause(s) and manner as tate and place, and due	stated. to the cause(s)

4a. Facility Name (If not institution, give services Ruxton Health 5. Social Security Number 221-22-0367 Usual Residence of Decedent 10a. State 10b. County DE Kent 10e. Street and Number 6150 Willow Gro	Care Cente 7. Age (In yr. 8) 10c. C Ve Road 2. Was Decedent Ever in Amed Forces? 1 \(\) Yes, Give Year or Dates:	s. last birthday) 3 2 Yrs. City, Town or Lo Camden-	Diff Under 1 Year Months Days ocation Wyomin 10f. Zip Code	Hours Min.	8. Date of Birth (Month, Day, 3 – 1 7 – 1	Day Year 2005 4c. County of Death Caroli Year) 9. Birth Con 923 Con	ne place (State or Foreign intry) necticut 10d. Inside City Limits 1 Yes 2 No
4a. Facility Name (If not institution, give s Ruxton Health 5. Social Security Number 221-22-0367 Usual Residence of Decedent 10a. State 10b. County DE Kent 10e. Street and Number 6150 Willow Gro 11. Marital Status 1 Never Married 28 Married 3 Widowed 4 Divorced	Treet and number) Care Cente M 2 F 7. Age (In yr. 8) 10c. C Ve Road 2. Was Decedent Ever in Amed Forces? 1	s. last birthday) 3 2 Yrs. City, Town or Lo Camden-	Diff Under 1 Year Months Days ocation Wyomin 10f. Zip Code	enton If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 3 – 1 7 – 1	4c. County of Deatt Caroli Year) 923 9. Birth Con 923 Con	ne place (State or Foreign intry) necticut 10d. Inside City Limits 1 Yes 2 No
Ruxton Health 5. Social Security Number 6. Sex 221-22-0367 Usual Residence of Decedent 10a. State 10b. County DE Kent 10e. Street and Number 6150 Willow Gro 11. Marital Status 1 Never Married 2x Married 3 Widowed 4 Divorced	Care Cente 7. Age (In yr. 8) 10c. C Ve Road 2. Was Decedent Ever in Amed Forces? 1 \(\) Yes, Give Year or Dates:	s. last birthday) 3 2 Yrs. City, Town or Lo Camden-	Diff Under 1 Year Months Days ocation Wyomin 10f. Zip Code	enton If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 3 – 1 7 – 1	Caroli Year) 9. Birth Col. 923 Con	ne place (State or Foreign intry) necticut 10d. Inside City Limits 1 Yes 2 No
5. Social Security Number 221 - 22 - 0367 Usual Residence of Decedent 10a. State 10b. County DE Kent 10e. Street and Number 6150 Willow Gro 11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced	Ve Road 2. Was Decedent Ever in Armed Forces? 1 Yes 2 2 2 No 1 Yes 7 Yes 7 Yes 7 Yes 7 Yes 7 Yes 7 Yes 7 Yes 7 Yes 7 Yes 7 Yes 7 Yes 7 Yes 8 Yes 7 Yes 8 Yes 7 Yes 8 Yes 7 Yes 8 Yes 7 Yes 8 Yes 7 Yes 8 Yes 7 Yes 8 Yes 7 Yes 8 Yes 7 Yes 8 Yes 7 Y	s. last birthday) 3 2 Yrs. City, Town or Lo Camden-	if Under 1 Year Months Days ocation - Wyomin 10f. Zip Code	H Under 24 Hrs. Hours Min.	(Month, Day, 3 – 1 7 – 1	9. Birth Con 923 COn	place (State or Foreign Intry) necticut 10d. Inside City Limits 1 Yes 2 Ilo
221-22-0367	Ve Road 2. Was Decedent Ever in Armed Forces? 1 Yes 2 2 2 No 1 Yes 7 1 Yes 7 2 2 No 1 Yes 7 2 Yes 7 1 Yes 7 1 Yes 8 1 Yes 8 1 Yes 8 1 Yes 8 1 Yes 7 1 Yes 8 1 Yes 8 1 Yes 7 1 Yes 8 1 Yes 8 1 Yes 7 1 Yes 8 1 Yes 7	32 Yrs. City, Town or Lo Camden-	months Days cocation Wyomin 10f. Zip Code	Hours Min.	(Month, Day, 3 – 1 7 – 1	923 Con	necticut 10d. Inside City Limits 1 Yes 2 No
Usual Residence of Decedent 10a. State DE Kent 10b. County DE Kent 10c. Street and Number 6150 Willow Gro 11. Marital Status 1 Never Married 3 Widowed 4 Divorced	Ve Road 2. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	City, Town or Lo	-Wyomin			Og. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
DE Kent 10e. Street and Number 6150 Willow Gro 11. Marital Status 1 Never Married 2x Married 3 Widowed 4 Divorced	Ve Road 2. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	u.s. 13.	-Wyomin		10		1 Yes 2 Xio
3 ☐ Widowed 4 ☐ Divorced	Ve Road 2. Was Decedent Ever in Armed Forces? 1	U.S. 13.	10f. Zip Code		10		
3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	ì		19934	10		intry?
3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	ì	Was Decedent of	19934			
3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	ì		Hispanic Origin? (Sp	ecify Ves or No.	USA 14. Race - Amer	ican Indian
15. Decedent's Educ (Specify only highest grade) Elementary/Secondary (0-12)	ation		If Yes, specify Cub 1 ☐ Yes 2 X No	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	Rican, etc.)	Black, White	
Elementary/Secondary (0-12)			dent's Usual Occu	pation during most of work	ing 1	6b. Kind of Business/I	ndustry
12	College (1-4or 5+)	life.	DO NOT use retire	ed)	ang		
		Bı	utcher	1		Meat	
17. Father's Name (First, Middle, Last) Joseph Kling					e (First, Middle, M	1	
	a Printl	10h Maili	an Address /Ctran				- O- 4-)
1							
20a. Method of Disposition		Place of Dispo	osition (Name of		-		
	emoval from State	-			7/05	Dovor	DE
		22	2. Name and Addre	ess of Facility Pi	ppin Fu	neral Ho	me, Inc.
23a. Part V Enter the disease, or complete	cations that caused the de						Approximate
Immediate Cause (Final		-					Interval Between Onset and Death
resulting in death)	Due to (or as a conse	equence of):	W14000	ruid Er	~ 50115	in.	
Sequentially list conditions b						. /	
if any, leading to immediate	Due to (or as a conse	equence of):			. 1	11	
that initiated events resulting in death) Last	Due to (or as a conse	anuence of):		A 1	MIN	EXAMINER	
L _d				NN APP	PROVED BY MEDICA	1200	
IS SEMALE.		1000		CERTIFICATE			
23b. Was decedent pregnant in the past 12 months? 1	1☐Live birth 2☐Fe	tal death 3					rery Day Year
Part II. Other significant conditions conf	tributing to death but not re	sulting in the u	ınderlving cause gr	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
					1 🗌 Yes	s 2 1⊘ No 3⊟Pro	bably 4 Unknown
			<u> </u>		24a Wasan	24h Ware aut	opsy findings available
					autopsy	prior to co	ompletion of cause of
				26 Place of Deat		V	2□ No
examiner?	ospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3□ DOA Ot				fy)
27. Manner of Death 1			of 28c. Inju	iry at ork?	28d. Describe hov	w injury occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rui State) 420 Co	al Route Number,
(Check only 2 Medical Examin	ician: To the best of my kiler: On the basis of exami	nowledge, deat	th occurred at the ti	ime, date and place,	and due to the car	MD use(s) and manner as	stated.
	and manner stated.		29c. Licens	se number	29	d. Date signed (Month	Day Year)
	- 4.5	,					
30. Name and address of person who con							
	\3L	Leda	nA my	e Presi	amos	21455	
31. Date filed (Month, Day, Year)			~		-		
JUL 2 6 20	05	À.	Local .				
	7	7	-				
	19a. Informant's Name/Relationship (Type Donald Kling — 20a. Method of Disposition 1 Surial 2 Cremation 3 Relationship (Type Donald Kling — 20a. Method of Disposition 1 Surial 2 Cremation 3 Relationship (Type Specify) 21. Signature of Funeral Service License Specify (Type Specify) 23a. Part1 Enter the disease, or complete Shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions con the past 12 months? 25 Was case referred to medical examiner? 26 Accident Specificant Conditions Con Cause (Disease) or injury that initiated events resulting in death) 27. Manner of Death Could not be determined 28. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who con Cause (Disease) 31. Date filed (Month, Day, Year)	Donald Kling — son 20a. Method of Disposition 1	19a. Informant's Name/Relationship (Type, Print) Donald Kling — son 126 20a. Method of Disposition 1 Removal from State 1 Characteristic C	19a. Informant's Name/Relationship (Type, Print) Donald Kling — son 126 Mourni 20a. Method of Disposition 1 Removal from State 1 Ceremation 3 Removal from State 1 Coremation 5 Other (Specity) Lakeside Ceme 21. Signature of Evneral Service Licensee 22. Name and Addr 119 W. C 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only/one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a	19a. Informant's Namer/Relationship (Type, Print) Donald Kling — Son 12b. Mailing Address (Street and Number or Runt) Donald Kling — Son 12c. Mourning Dove 12d. Mourning Dove 12d. Mourning Dove 12d. Mourning Dove 2a. Method of Disposition 12d. Disposition (Name of cemellary or other place) 12d. Date of Disposition (Name of cemellary creamatory or other place) 12d. Date of Disposition (Name of cemellary creamatory or other place) 11d. Date of Disposition (Name of cemellary creamatory or other place) 11d. Date of Disposition (Name of cemellary creamatory or other place) 11d. Date of Disposition (Name of cemellary creamatory or other place) 11d. Date of Disposition (Name of cemellary creamatory or other place) 11d. Date of Disposition (Name of cemellary creamatory or other place) 11d. Date of Disposition (Name of cemellary creamatory or other place) 11d. Date of Disposition (Name of cemellary creamatory or other place) 11d. Date of Disposition (Name of cemellary creamatory or other place) 11d. Date of Committee of Section (Name of Cemellary Creamatory or other place) 11d. Date of Committee of Section (Name of Cemellary Creamatory or other place) 11d. Date of Committee of Disposition (Name of Cemellary Creamatory or other place) 11d. Date of Committee of Section (Name of Cemellary Creamatory or other place) 11d. Date of Committee of Cemellary Creamatory or other place) 11d. Date of Committee of Cemellary Creamatory or other place of Cemellary Creamatory or other place of Disposition (Name of Cemellary Creamatory or other place) 11d. Date of Cemellary Creamatory Cre	19b. Mailing Address (Street and Number or Rural Route Number.) Donald Kling — son 120. Method of Disposition (Name of 1880 and	19a. Informant's Name Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 Donald Kling — son 126 Mourning Dove Lane Dover, DE 20a. Method of Disposition (Prince of Development) 126 Mourning Dove Lane Dover, DE 20a. Method of Disposition (Prince of Development) 126 Mourning Dove Lane Dover, DE 20a. Leader of Date 20b. Clear of Disposition (Prince of Development) 126 Mourning Dove Lane Dover, DE 20a. Method of Development 126 Mourning Dove Lane Dover, DE 20a. Leader of Date 20b. Clear of Development 20a. Leader of Date 20b. Clear of Development 20

Amend# 8 per FD 7/21/07 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMCHD State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician July Hugo F. Koubik 14, 2005 1:00 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 404 Alameda Pkwy Arnold Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 12 M 2□F Months 80 Director Jan. <u>212-20-4689</u> MD 29 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Anne Arundel Directo Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 404 Alameda Pkwy 21012 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Peges 1 and 2 should be filed within 72 hours after 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married .0. Baltimore, Maryland 21215-0036 WII 1 ☐ Yes 2X No White Specify. ٥ Specify 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumatic event, Leagure. Concrete Foreman Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Victor Koubik Bessie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis A. Palmer/Daughter 404 Alameda Pkwy, Arnold, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Bohemian National July 20 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 2005 21. Signature of Fuperal Service Licensee Barranco & Sons, P.A., Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Pri1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a CHRONIC OBSTRUCTIVE PULMONARY BUSEASE **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed as the burial-transit attending physicien and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4_Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No No No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 ☐ Yes 2 No မှ Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? Certification: 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 102 3867 noms walse mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Farm ROAD ARNOLD MD 21012 277 Peninsula THOMAS WALSH MID

Registrar

31. Date filed (Month, Day, Year)

JUL; 1 9 2005



	E
Box 68760,	all or Attending Dhusician. The law requires that the death confined be executed
Box	too the op
, P.O. Bo)	that the
Records,	The less received
Vital	oloion.
ivision of	. According Dhy
	-

		Please T 1 - State Registrar	State of Maryland	/ Department of H		ental Hygier Reg. 1		25217
Physicia /Medic	an al	Decedent's Name (First, Middle, Last) JAMES A.	KLEMAN			2. Date of Death Month	Pay 2005	3. Time of Death
Examin	G!	4a. Fecility Name (If not institution, give THE MEMOL 5. Social Security Number 6. Sec	CIAL HOSPIT.	AL ZA	F Location of Death 4570 If Under 24 Hrs.	8. Date of Birth	4c. County of Death	807
Funeral Director	R		7. Age (III y is. ias	Yrs. Months Days	Hours Min.	EPT. 23, 19	28 PENN	place (State or Foreign ntry) SYLVANIA
death with the Maryland ms 23a or 28a-f ahow	Director	10a. State 10b. County MD QUEEN A		Town or Location GRASONVILLE				10d. Inside City Limits 1 ☐ Yes 2X No
ath with the 23s or 20		346 PROSPECT BAY		10f. Zip Code 2163			USA	
ours after ral', or ite	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 Mo If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2X No	Ispanic Origin? (Spec an, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Ameri Black, White Specify: WI	
permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic avant, the Medical Examina once.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+) 5+	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire TEACHER	during most of working	g 16b.	Kind of Business/Ir EDUCATION	
2 should be filed and Mental Hyg is marked other sumatic avant,	To Be C	17. Father's Name (First, Middle, Last) HARRY KLEMAN			18. Mother's Name (
and 2 sho ealth and I m 27 is ma her trauma		19a. Informant's Name/Relationship (Ty MRS. MARY LOUISE I	CLEMAN	19b. Mailing Address (Street 346 PROSPEC	T BAY WEST	, GRASON	VILLE, MD	21638
t. Pages 1 trant of H trant: If ite		20a. Method of Disposition 1 □ Burial 2 🛣 Cremation 3 □ F '4 □ Donation 5 □ Other (Specify) 21. Signatu/a of Funeral Service Licens	temoval from State CHESA CENT		ON JULY	16, 2005	STEVENS	VILLE, MD
Physician /Medical Examiner		23a. Pen1. Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Helfentien ications that caused the death.	enotic Ca	CK ROAD, C	HESTER, I	4D 21619	Approximate Interval Between Onset and Death
icate be executed physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	Due to (or as a conseque					
ath certif ittending or use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Ves} \ 2 \subseteq No \) 9 \(\text{Unknown} \)	3c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	eath 3 Ectopic pregnancy	y		23d. Date of deliv Month	rery Day Year
w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions con	ntributing to death but not resulti	ing in the underlying cause giv	en in Part I.		o use contribute to	
n: The law r cate has be r, page 2 sh	Completed					24a. Was an autopsy performed 1 Yes 2	prior to co death?	opsy findings available ompletion of cause of
To the Hospital or Attanding Physician: The Is within 2 Hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page:	Certification; To Be	27. Manner of Death 1 Natural 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	8b. Time of 28c. Injury Wo	y at 28 rk? Yes 2 □ No	e 5 Tesidence		
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	al Certif	4 Homicide determined 29a. Certifier 1 Certifying Phy	building, etc. (Specify) sician: To the best of my knowl	e, farm, street, factory, office	me, date and place, ar	City or Town, St	(s) and manner as	www.assassassassassassassassassassassassass
To the Ho within 24 h To the Fu completely	Medical	(Check only 2 Medical Exami	ner: On the basis of examinatio and manner stated.	29c. Licens		29d.	Date signed (Month,	Day, Year)
0.	te	30. Name address of person who co CYNTHIA CHEN, 31. Date filed (Month, Day, Year)	M D 210 C W	ACHTNOTON ST	EASTON, M	1D 21601		
	1 3 ÷ 4	IIII a A	000-					

		For State		'ype or Pri		d/D		nt of H	lealth and	•	ygiene		
Physicia /Medic			ne (First, Middle, Last)	era C	ann		Kn	epp	er	2. Date of I Month	Day	2005	G. Time of Dear
Examin Funeral Director	er	1024 AV 5. Social Security 280-26-3	338 ^{1□}		ge (In yrs. 75		ST	EVENS	VILLE If Under 24 Hr Hours Min	s. 8. Date of E	Q1 Birth Day, Year)	- 00	NE S hplace (State or For nuntry)
show	-	Usual Residence	10b. County		10c. Cit	y, Town	or Location						10d. Inside City Lin
or 28a-f	Director	MD 10e. Street and No	QUEEN AN	NE'S	ST	EVEN	SVILLE 10f. a	Zip Code			10g. Cit	izen of What Co	
ntal Hygiene. style than "natural", or items 23a or 28a-f show event, the Medical Evanturer must be notified at	by Funeral	11. Marital Status	ALON COURT	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:	?	S.	13. Was Dec If Yes, sp	2 No	ispanic Origin? (in, Mexican, Pue Specify:	Specify Yes or I	-	JSA 14. Race - Ame Black, Whit Specify:	
- 92	Completed	(Spec	15. Decedent's Educify only highest grade ondary (0-12)	cation	5+)	1	Decedent's Us 'Give kind of valide. DO NOT	vork done use retired	during most of w l)	orking		ind of Business	•
and Mental Hygiene is marked other than aumatic event, I'm M.	Be		(First, Middle, Last) R. SHERRAI	RD						ame (First, Mida	lle, Maiden		
	10	19a. Informant's h	Name/Relationship (Ty	рө, Print)					and Number or F	Rural Route Num	ber, City o		Zip Code)
t of Health if item 27 or other tr		JOSEPH 20a. Method of Di	E. KNEPPER	, JR.	20b. P	lace of I	24 AVA Disposition (A	ame of		TEVENSVI Date		MD 216 ocation - City or	
Department of important: if it any injury or o		21. Signature of 5	of Other (Specify) of the disease, or compart failure. List only of	The	`		FELLO 106 S	and Addre	ss of Facility ELFENBET CK ROAD	CHESTE	NAM F		Approximate
nysician Medical xaminer		Immediate Cause disease or condit resulting in death	on a a	Due to (or as	(L	0/0		can				Onset and Deat Mee
ıysician and ne burial-transit	ical Examiner	if any, leading to it cause. Enter Und Cause (Disease of that initiated even resulting in death)	mmediate lerlying rinjury ts	Due to (or as									
ate has been signed by the attending physic page 2 should be detached for use as the b	Physician/Medic	IF FEMALE: 23b. Was decede in the past 1: 1 Yes 2 9 Unknow	2 menths?	3c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Feta	l death	3 □Ectopic 5 □ Other (23d. Date of del Month	ivery Day Year
been signed t	by	Part II. Other sign	ificant conditions con	ntributing to death b	out not res	ulting in	the underlying	cause giv	en in Part I.				the cause of death
	Completed									pe	is an copsy formed?	24b. Were au prior to death?	topsy findings avail completion of cause
	o Be	25. Was case reference examiner?		lospital:	ent 2 🗆	ER/Out	patient 3 [OCA Oth	ac.	eath <i>(Check onl</i>) Home 3 Re		6 □Other (Spe	cify)
After fune	atlon: T	27. Manner of Dea	5 ☐ Pending investigation	28a. Date of Inju (Month, Da		28b. Ti		28c. Injun Wor	/ at	28d. Describ			, , , , , , , , , , , , , , , , , , ,
within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of In building, el	jury - At ho tc. <i>(Specif</i>	ome, fari y)	m, street, facto	ory, office		28f. Location City or 7	(Street an own, State	d Number or Ru)	ral Route Number,
within 24 hours after To the Funeral Dir completely filled in	Medical (29a. Certifier (Check only one)	1 Certifying Phys 2 ☐ Medical Examin	ner: On the basis of and manner st	of examina lated.	tion and	or investigation	on, in my o	pinion, death occ	curred at the time	e, date and	place, and due	to the cause(s)
withir To th comp	Me	29b. Signature an	d title of certifier	n		7	2	9c. Licens	number	0	29d. Dai	e signed (Monti	n, Day, Year)
		_ /			/			9	(420	م ا	01	1-14	-05
Sta	te ar	31. Date filed (Mo	Sees of person who co See Merican nth, Day, Year) JUL 1.5	32. Registr	S Signa	Cro	iype, erint)	hway	Ste. 4	06, GI	in B	uniel	n, Day, Year)

			For Amended line State of Maryland 1-State Pegistran 17 per fh/tlv 7/29/05	/ Depa	artment of H	leaith and M	ental Hyg	jiene nn 5	25210
				Cer	tificate of I	Death			25349
	Physici	an	Decedent's Name (First, Middle, Last)				Date of Dea Month	Day Year	
	/Medic		Charles Leroy King 4a. Facility Name (If not institution, give street and number)		4b Cib. Town or	Lanction of Decision	July	19 200	
	Examin	er	· ·			Location of Death		4c. County of Dea	ath
	Funeral		1023 St. Michaels Road 5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday)		Alry If Under 24 Hrs.	8. Date of Birth	Howard	thplace (State or Foreign
	Director		214-34-6530 ^{1⊠M 2□F} 65	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day May 28,	1940 Mar	ountry) Syland
_	p ,		Usual Residence of Decedent 10a. State 10b. County 10c. City.	_					
	shor	or.		Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28a-f	Directo	Maryland Howard N	Mount	1			10-00	
	with with		1023 St. Michaels Road		10f. Zip Code	771		log. Citizen of What C	•
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	. 13. V	1 -		cify Yes or No-	United S	
٥	or ite	Fur	Armed Forces? 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No			ispanic Origin? (Spe in, Mexican, Puerto I	Rican, etc.)		ite, etc.
1215-0036	within 72 hours after death with the Maryland one. than "natural", or items 23s or 28s-f show items "Mardical Examinal mint be nutilled at	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1	∐Yes 2⊠XNo	Specify:		Specify: W	nite
5	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give	lent's Usual Occupa	ation during most of workii)	ng	16b. Kind of Business	s/Industry
7	withir ane. than	dmo	Elementary/Secondary (0-12) College (1-4or 5+)			" nt Operato		E	•
D	filled Hygid other	e Cc	17. Father's Name (First, Middle, Last)	Heavy	Edarbiie	18. Mother's Name		Excavat:	ing
and	ld be ental ked c	To B	Charles Leroy King, Sr. Elmer L	. Kin	g	Mabel T:		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
ary	shou and M mar umat	_	19a. Informant's Name/Relationship (Type, Print)					r, City or Town, State,	Zip Code)
Ma,	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, "to Medical Examinal must be notified at		Laura Ann Brown King / Wife	1023	St. Micha	aels Road	Mt. A	iry, Maryla	and 21771
ore	of He of He or oth		20a. Method of Disposition 1 ☐ Burial 2 ত Cremation 3 ☐ Removal from State	nce of Dispos	sition (Name of natory or other plac	0.1		20c. Location - City or	Town, State
Ē	Pag ment ant:		`4 □Donation 5 □Other (Specify) Fred		Cremato		oog ' j	Frederick,	Maryland
Saitimor	permit. Pages 1 Depertment of H Important: If its eny injury or ot once.		21. Signature of Funeral Service Licensee	22.	. Name and Addres	s of Facility Stat	ıffer Fu	ineral Home	es, P.A.
	40200		230 Part I Enter the disease or some lieuting that accord the death					Airy, MD	
			23a. Part1. Enter the disbased or complications that caused the death. shock, or heart failure—List only one cause on each line. Immediate Cause (Final						Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a	256-0	tic	esopo	kay.	->/	
	Examiner		Due to (or as a conseque						* **
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ence of):	- (100)	277			7 - 70
	acuter indi	Examin	Cause (Disease or injury that initiated events c						
Ď,	be executed ician and burial-transit	E	Due to (or as a conseque	ence of):					
09/99	icate be executed physician and s the burial-transit	dlcal	d						
XOD	ng a s	豆							
\simeq	DE SE	0	IF FEMALE: 23c. If yes, outcome of pregnance	cv				224 Data at 4	
Ü	death certific	0	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnanc	death 3□	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
	it the death certificate by the attending phys tached for use as the	0	23b. Was decedent pregnant in the past 12 months?	death 3□					,
Ο	es that the death ce gned by the attendi be detached for use	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 2 No 43c. If yes, outcome of pregnanc 1 Live birth 2 Fetal december 4 Pregnant at time of dea	death 3 death 3 death 5 death 5 death	Other (specify)	en in Part I.	23e. Did tol		Day Year
Ο	equires that the sen signed by the	by Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnanc 1 Live birth 2 Fetal december 4 Pregnant at time of dea	death 3 death 3 death 5 death 5 death	Other (specify)	en in Part I.	23e. Did tol	Month bacco use contribute to	Day Year
-	aw requires that the as been signed by th 2 should be detache	by Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnanc 1 Live birth 2 Fetal december 4 Pregnant at time of dea	death 3 death 3 death 5 death 5 death	Other (specify)	en in Part I.		Month Dacco use contribute to as 2 3 P	Day Year o the cause of death? robably 4 Unknown
Hecords, P.O.	The law requires that the ate has been signed by the page 2 should be detache	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnanc 1 Live birth 2 Fetal december 4 Pregnant at time of dea	death 3 death 3 death 5 death 5 death	Other (specify)	en in Part I.	1 Ty	Month bacco use contribute to as 2 3 P	Day Year o the cause of death? robably 4 Unknown utopsy findings available completion of cause of
Ο	The law requires that the ate has been signed by the page 2 should be detache	Be Completed by Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting	leath 3 □	Other (specify)	26. Place of Death	24a. Was a autops perform 1 Yes 2	Month pacco use contribute to the set of th	Day Year to the cause of death? robably 4 □Unknown utopsy findings available completion of cause of 2 □ No
or vital Records, P.O.	Physician: The law requires that the this certificate has been signed by that director, page 2 should be detached.	To Be Completed by Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting	leath 3 the 5 the	Other (specify) Identifying cause give	26. Place of Death	24a. Was a autops perform 1 Yes (Check only onle 5 eside	Month pacco use contribute to the set of th	Day Year to the cause of death? robably 4 □Unknown utopsy findings available completion of cause of 2 □ No
or vital Records, P.O.	Physician: The law requires that the this certificate has been signed by that director, page 2 should be detached.	To Be Completed by Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resul	leath 3 □	Other (specify) Iderlying cause give 3 □ DOA Other 28c. Injury Work	26. Place of Death	24a. Was a autops perform 1 Yes (Check only onle 5 eside	Month pacco use contribute to the set of th	Day Year to the cause of death? robably 4 □Unknown utopsy findings available completion of cause of 2 □ No
or vital Records, P.O.	Physician: The law requires that the this certificate has been signed by that director, page 2 should be detached.	To Be Completed by Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resul	leath 3 the state of the stat	Other (specify) Iderlying cause give 3 □ DOA Other 28c. Injury Work M 1 □ N	26. Place of Death 37. 4 □ Nursing Hom at 27. Yes 2 □ No	24a. Was a autops perform 1 Yes 2. (Check only on the 5 periods and Describe house)	Month pacco use contribute to the set of th	Day Year to the cause of death? robably 4 Unknown utopsy findings available completion of cause of 2 No
Vital Records, P.O.	Physician: The law requires that the this certificate has been signed by that director, page 2 should be detached.	o Be Completed by Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resul	leath 3 the state of the stat	Other (specify) Iderlying cause give 3 □ DOA Other 28c. Injury Work M 1 □ N	26. Place of Death 37. 4 □ Nursing Hom at 27. Yes 2 □ No	24a. Was a autops perform 1 Yes (Check only on the 5 Reside 8d. Describe ho	Month pacco use contribute to the set of th	Day Year to the cause of death? robably 4 Unknown utopsy findings available completion of cause of 2 No
or vital Records, P.O.	Physician: The law requires that the this certificate has been signed by that director, page 2 should be detached.	Certification; To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resul	leath 3 the understand the underst	Other (specify) Iderlying cause give 3 □ DOA	26. Place of Death 37. 4 Nursing Hom at 27. Yes 2 No	24a. Was a autops perform 1 Yes (Check only on the 5 deside 8d. Describe house 1 to 1 to 1 to 1 to 1 to 1 to 1 to 1 t	Month bacco use contribute to the set of th	Day Year to the cause of death? robably 4 Unknown utopsy findings available completion of cause of 2 No wcify)
or vital Records, P.O.	Physician: The law requires that the this certificate has been signed by that director, page 2 should be detached.	To Be Completed by Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resul	leath 3 the understand the underst	Other (specify) Iderlying cause give 28c. Injury Work M 1 28t. Injury Work A tactory, office occurred at the timestigation, in my open	26. Place of Death 37. 4 Nursing Hom at 27. 7 4 Nursing Hom at 27. 2 No 2 Lee, date and place, a sinion, death occurre	24a. Was a autops perform 1 Yes (Check only on the 5 Describe house and the state of the control	Month bacco use contribute to the set of th	Day Year to the cause of death? robably 4 Unknown utopsy findings available completion of cause of 2 No wcify) ural Route Number, s stated.
or vital Records, P.O.	lending Physician: The law requires that the feath. tor: After this certificate has been signed by the the funeral director, page 2 should be detache	edical Certification; To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resul	leath 3 the understand the underst	Other (specify)	26. Place of Death 27. 4 Nursing Hom at 27. Yes 2 No 2 lee, date and place, a sinion, death occurred a number	24a. Was a autops perform 1 Yes (Check only on the 5 Seside 8d. Describe house of the City or Town at the time, d	Month pacco use contribute to the set of th	Day Year of the cause of death? robably 4 Unknown utopsy findings available completion of cause of security. wral Route Number, s stated. a to the cause(s)
or vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	edical Certification; To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resul	Aleath 3 state of the state o	Other (specify)	26. Place of Death 37. 4 Nursing Hom at 27. 7 4 Nursing Hom at 27. 2 No 2 Lee, date and place, a sinion, death occurre	24a. Was a autops perform 1 Yes (Check only on the 5 Seside 8d. Describe house of the City or Town at the time, d	Month bacco use contribute to the set of th	Day Year of the cause of death? robably 4 Unknown utopsy findings available completion of cause of security. wral Route Number, s stated. a to the cause(s)
oi vital necords, P.O.	Physician: The law requires that the this certificate has been signed by that director, page 2 should be detached.	edical Certification; To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resul	Aleath 3 state of the state o	Other (specify)	26. Place of Death 27. 4 Nursing Hom at 27. 7es 2 No 28. No 29. No 29. No 20.	24a. Was a autops perform 1 Yes (Check only on the 5 Reside 8d. Describe house of the control of	Month pacco use contribute to the set of th	Day Year of the cause of death? robably 4 Unknown utopsy findings available completion of cause of secify) ural Route Number, s stated. a to the cause(s) th, Day, Year)
oi vital necords, P.O.	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical Certification; To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resul	R/Outpatient 18b. Time of Injury 1e, farm, stre	Other (specify)	26. Place of Death 27. 4 Nursing Hom at 27. 7es 2 No 28. No 29. No 29. No 20.	24a. Was a autops perform 1 Yes (Check only on the 5 Reside 8d. Describe house of the control of	Month bacco use contribute to the set of th	Day Year of the cause of death? robably 4 Unknown utopsy findings available completion of cause of secify) ural Route Number, s stated. a to the cause(s) th, Day, Year)

Physici	an	Decedent's Name (First, Middle, Las	Maria 📙				2. Date of D Month	eath Day	Vana	e of Death
/Medic		Ani Plane	- Na:	zandji	an		July		202 13,	P
Examir	er	4a. Facility Name (If not institution, give	11 .1	1	- 1.	or Location of De	eath	4c. County	_	
		The Johns Hopl 5. Social Security Number 6. Se		rs. last birthday)	If Under 1 Year	r If Under 24 F	drs a Data of B	i	lone	
uneral irector			□M 2XF 12	Yrs.	Months Days		lin. 8. Date of B (Month, D July	9 1993	9. Birthplace (Sta. Country) Paragua	te or Fore
_		Usual Residence of Decedent					July	7, 1555	raragaa	<u>Y</u>
show	-	10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside	
28e-f	ecto	MD Howard 10e. Street and Number		Laurel						es 2 🔀
a or	Funeral Director	8392 Sweet Cherry	Tano		10f. Zip Code 20723			10g. Citizen of W	•	
rns 23a	era	11. Marital Status	12. Was Decedent Ever in	1 U.S. 13. V			(Specify Yes or N		d States	
r Iter	F	1X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X No	lf If	and the second		(Specify Yes or N lerto Rican, etc.)	Black	k, White, etc.	
Fra.	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	Yes 2□No	Specify: L	atino	Specify:	Latino	
hatu	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	lent's Usual Occu	e during most of	warkina	16b. Kind of Bu	siness/Industry	
hen R Me	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retire	ed)				
ther int, it		17. Father's Name (First, Middle, Last)		Stu	dent	19 Mother's N	Jame (First Middle	Educat		
Is marked other then eumatic event, I've Me	To Be	Vahe A. Kazandjiar	1				M. Corri		θ)	
mari	ř	19a. Informant's Name/Relationship (T		19b. Mailin	a Address (Stree	1		per, City or Town, S	State Zin Codel	
em 27 ls other treu		Janet M. Corrigan/	Mother		Sweet Ch			1, MD 20		
= 0		20a. Method of Disposition	206	p. Place of Dispos cemetery, crem			Date		City or Town, State	,
ant: If		1 ØBurial 2 □ Cremation 3 □ I 1 4 □ Donation 5 □ Other (Specify,	Temoval hom State	St. Louis	_		21-2005	Clarksv	ille, MD	
Importent: If eny injury or once.		21. Signature of Funeral Service Licens	seeM01	044 22.	. Name and Addr				Family FI	H Ir
F P 의		Show Calle	, Wyle	41	112 Old	Columbia	a Pike El	licott C	ity, MD 2	2104
sician edical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	s Elect		and Activity	liac or respiratory a	arrest,	Approxin Interval B Onset an	Between
miner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Respirat	tory I	nsuffic	iency	-		48 h	ours
hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Pulmona Due to (or as a cons		emorrho	age			10 de	LYS
physicis s the bu	dical		d. Lupus	Erythe	matosu	رح			6 we	iks
by the attending patached for use as i	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3 🗌	Ectopic pregnand Other (specify)	су		23d. Date Mont	e of delivery th Day	Year
s been signed to should be det	by P	Part II. Other significant conditions co		esulting in the un	derlying cause gi	iven in Part I.	23e. Did	tobacco use contril	bute to the cause o	of death
en sig	edt	Kenal Insuf	ficiency				10	Yes 2/2 No	3 Probably 4 [□Unkno
2 sho	Completed	1 A 1 A	lemia .				24a. Was		/ere autopsy finding	gs availa
CD C4	mo:							ormed? de	rior to completion o eath? □ Yes 2☑ No	f cause
ate has page 2	Be (25. Was case referred to medical examiner?			1.1	26. Place of D	eath (Check only		22110	
artificate has		1 ☐ Yes 2 ☑ No		☐ ER/Outpatient	3 DON		Home 5□Resi	dence 6 Other	r (Specify)	
s certificate director, pag	မ	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo		28d. Describe	how injury occurre	ed	
fter this certificate ineral director, pag	lon; To	1 ☑ Natural 5 ☐ Pending				Yes 2 No				
After this certificate funeral director, pag	ication; To	2 Accident investigation 3 Suicide 6 Could not be	Office of the same of		et factory office		28f. Location (City or To	Street and Number wn, State)	r or Rural Route Nu	ımber,
After this certificate funeral director, pag	ertification; To	2 Accident investigation	28e. Place of Injury - At building, etc. (Spe	nome, farm, stre cify)	ot, lactory, office					
After this certificate funeral director, pag	Certification;	2 Accident 3 Suicide 4 Homicide investigation 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe sician: To the best of my kiner: On the basis of examinand manner stated.	cony)	occurred at the ti	ime, date and pla opinion, death oc	ce, and due to the	cause(s) and man date and place, ar	nner as stated. nd due to the cause	∍(s)
fter this certificate ineral director, pag	Medical Certification; To	2 Accident 3 Suicide 4 Homicide investigation 6 Could not be determined	sician: To the best of my k iner: On the basis of exami and manner stated.	cony)	occurred at the ti	opinion, death oc	ce, and due to the curred at the time,	date and place, ar	nner as stated. nd due to the cause (Month, Day, Year,	
After this certificate funeral director, pag	edical Certification;	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) Condition investigation 6 Could not be determined	sician: To the best of my kiner: On the basis of exami	cony)	occurred at the ti estigation, in my of 29c. Licens	opinion, death oc	ce, and due to the courred at the time,	date and place, ar	nd due to the cause	

			1 - For State Registrar	State of Man	yland / Depa <i>Cer</i>	irtment of F	lealth and N Death		jien 2 () () (5 25351
			Decedent's Name (First, Middle)	, Last)				2. Date of Deat	th	3. Time of Death
н	Physici /Medio		FRIEDA	ERNA	LI	NDER		JULY	Day Ye 20	9ar 05 8:25 A M
}	Examir		4a. Facility Name (If not institution	,			r Location of Death		4c. County of I	
			22606 AQUASCO			AQUAS				GEORGE'S
L	Funeral Director		5. Social Security Number 151–16–1283	6. Sex 7. Age (li 1 1 M 2 N F	n yrs. last birthday) 81 ^{Yrs.}	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
			Usual Residence of Decedent		81			MAY 31,	1924 N	EW JERSEY
	how		10a. State 10b. County	10	Oc. City, Town or Lo	cation				10d. Inside City Limits
	Ba-fs	cto	MD PRINCE	E GEORGE'S	AQUASCO					1 ☐ Yes 2 XNo
	with th	Director	10e. Street and Number	2015		10f. Zip Code		1	0g. Citizen of Wha	•
	eath is 236	erai	22606 AQUASCO F	12. Was Decedent Eve	rin II S 13 V	20608	lispanio Origin? (Sp	coifu Vac ar No	U. S.	A. American Indian,
936	2 should be tiled within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "neturel", or Items 23e or 28e-f show eumetic event, the Medical Examiner must be neithed at	by Funerai	1 ☐ Never Married 2 ☐ Marr 3 🖫 Widowed 4 ☐ Divorced	Armed Forces?	1	Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		White, etc.
21215-003	72 ho netur	Completed	15. Decedent (Specify only highes		16a. Deced	ent's Usual Occup	ation during most of work	ina	16b. Kind of Busin	
2	s tiled within 72 h I Hygiene. other than "nett ent, Ire Moder	mpie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired	d)	,,,g		
	Hygie ther t		17. Father's Name (First, Middle,	(ast)	HOU	SEWIFE	18. Mother's Name	e (First Middle A	AT HOME	
Maryland	d be sental l	To Be	RICHARD KRIEGER	·			ELSIE KL			
ary	should ind Men marke umetic	-	19a. Informant's Name/Relations	nip (Type, Print)	19b. Mailin	g Address (Street	and Number or Rura			te, Zip Code)
	end 2 salth a n 27 is		JUNE M. STANLEY	/ DAUGHTER	22606	AQUASCO	ROAD AQU	ASCO. MA	RYLAND 2	0608
altimore,	t te i		20a. Method of Disposition 1 □ Burial 2 🛣 Cremation		20b. Place of Dispos				20c. Location - City	
Ĕ	Pages tment of tent: If It jury or o		`4 □ Donation 5 □ Other (S)	pecify)	BRINSFIEL		CR. 20	05 C		HALL, MD
Bal	permit. Pages Department of Importent: If I any injury or once.		21. Signature of Funeral Service	ast at	M00641 30	195 THRE	E NOTCH R	D. CHARL	OTTE HAL	UNL.HME.,P.A. L, MD 20622
				complications that caused the only one cause on each line.	death. Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Mesh	DMA	8411	~ CO	100	morphs
	Examiner			Due to (or as a co	onsequence of);					
		Jer	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a co	onsequence of):					
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	c						
Ď,	cate be executed physician and the burial-transit	I Ex	resulting in death) Last	Due to (or as a co	onsequence of):					
8760,	cate phy: the	dical		d			-			
D.		(a)	IF FEMALE:	23c. If yes, outcome of p	pregnancy			***************************************	22d Date of	dollaran
Box	death certit e attending od tor use as	Physician/M	23b. Was decedent pregnant in the past 12 menths? 1 \sum Yes 28 No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	Day Year
J.	at the de by the a	hys	9 Unknown	9□ Unknown				_		
ecords, l	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant condition	ns contributing to death but n	ot resulting in the un	derlying cause give	en in Part I.	23e. Did tob	L/	e to the cause of death? Probably 4 Unknown
ecc	law re as be	Completed						24a. Was an		a autopsy findings available to completion of cause of
II.	The lav	Con						perform		h?
Vital	iclen: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospitali		1011	26. Place of Death	/		
o	Phye this ral di	- To	1 ☐ Yes 2 No 27. Manner of Death		2 ER/Outpatient		4 Li Nursing Ho		nce 6 Other (5	Specify)
O	Attending for death. ector: Atter by the funer	ertification:	1 Accident 5 Pending		ear) Injury	28c. Injun Worl	k? Yes 2 □ No	200. Describe no	w injury occurred	
Division	ial or Attendi s atter death. al Director: A ad in by the fu	iffica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place of Injury	- At home, farm, stre	et, factory, office		28f. Location (Str	reet and Number o	r Rural Route Number,
2	tal or	Cert	4 E Homeido	building, etc. (S	эр в спу)			City or Town	, State)	
	To the Hospital within 24 hours at To the Funerel Completely tilled it	edical	29a. Certifier Certifying (Check only one)	g Physician: To the best of m Examiner: On the basis of exa and manner stated	amination and/or inv	occurred at the timestigation, in my of	ne, date and place, a pinion, death occurr	and due to the ca ed at the time, da	use(s) and manne ate and place, and	r as stated. due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	H		29c. License	number	29	d. Date signed (M	onth, Day, Year)
				-1		DI	1731	J	ULY 18,	2005
1	85		30. Name and address of person of FRANK M. RYAN,				[ጥፑ 1በኃ ^{፲፱} ፻	T.T.A.C.T.T	MOTON NO	207//
6	Sta	te	31. Date filed (Month, Day, Year)	32. Redistrar's	Signature		LIE 103 F.	L. WASHI	NGION, M	J 20/44
	Registr		JUL 2) 2005 Meseus	JA A	review				

			For State	State of Marylar	nd / Depa	artment o	f Health a	and Me	ntal Hygi			25352
			1 - State Registrar 1. Decedent's Name (First, Middle, La:		Cei	rtificate d	of Death		Reg	. No.	000	10002
	Physici	an		•					. Date of Death Month	Day	Year	3. Time of Death
	/Medio		Joseph John Le			4b Ciby Tour	n, or Location o		July	23, 2 4c. County		11:25 AM ^M
	CXAIIIII	er ÷	23326 Red Oak Cou					Death				•
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.	last birthday)	If Under 1 Ye			. Date of Birth		Mary 9. Birthpla	
	Director		331-24-6636	ZM 2□F 7	5 Yrs.	Months Da	ys Hours	Min.	(Month, Day,) ov. 23,	1929	Country Illi	ce (State or Foreign y) nois
	w w		Usual Residence of Decedent 10a. State 10b. County	10c Ci	ty, Town or Lo	anting						
	Manyli f sho	ō									100	d. Inside City Limits 1 ☐ Yes 2√√√No
	28e	rect	Maryland St. Ma 10e. Street and Number	ry's C	aliforr	11a 10f. Zip Cod	le .		100	. Citizen of V	Mhat Carreta	
	3a ou	Funeral Director	23326 Red Oak 0	lourt		206			105	U.S.A		y :
	deat	nera	11. Marital Status	12. Was Decedent Ever in U			of Hispanic Orig Cuban, Mexican,	gin? (Specif	y Yes or No-		e - Americar	n Indian,
9	or its	y Fu	1 ☐ Never Married 2 ▼ Married	Armed Forces? 1 XYes 2 No If Yes, Give 19	-	1 ⊡Yes 2 📆 i		, Puerto Hio	can, etc.)		k, White, et	c.
21215-0036	within 72 hours after death with the Maryland one. Itan "natural", or Items 23a or 28e-f show the Modical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:						Specify	Whit	te
7	in 72	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	dent's Usual Oc kind of work do DO NOT use re	ne during most	of working	16	b. Kind of Bu	ısiness/îndu	stry
77	iene.	шо	Elementary/Secondary (0-12)	College (1-4or 5+) 2			Techni	cian	1	Defe	naa	
פ	e filed Il Hygie other	BeC	17. Father's Name (First, Middle, Last)		11181	IC ICSC			First, Middle, Ma			
<u>Ja</u>	Wents Wents urked	To E	Andrew Lesko				Anna	a Fatı	ula			
Maryland	2 sho and ls ma		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailin	g Address (Str	eet and Number	r or Rural F	loute Number, (ity or Town,	State, Zip C	ode)
≥ o`	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparment of Health and Mental Hygiene. Department of Health and Mental Hygiene. The most second the them of the them and the them are the most second any injury or other treumatic event, the Medical Examiner must be notified at once.			ife	23326	Red 0a	ak Court	t Cal	ifornia	Mary	land 2	20619
Baltimore,	Pages 1 nent of H nnt: If ite iry or ot		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □			sition (Name of natory or other		Date	20	c. Location -	City or Town	n, State
ij	it. Pa rtmen rtent: njury		* 4 ☐ Donation 5 ☐ Other (Specify) 1 St		s Ceme		7-25		Clinto	n, Mai	ryland
Ba	Dep Dep Impo any i		21. Signature of Funeral Service Licen	SO Mann								ne, P.A.
	-		23a. Part1. Enter the disease, or comp	plications that caused the deat	Do not ente	0.0. Box	× 279 L€	eonard	ltown, N	faryla:		50-0279
П	Obveision		shock, or heart failure. List only immediate Cause (Final	ohe cause on each line.	14		1			•	ir	opproximate nterval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a conseq		4784311	n 100	Marce	. 11 cyr		W.	341
п	Examiner			ISCHEMI	CAR	SICMY	DATH	Y			Y	CAN
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq								, -
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
8760,	cate be executed by sician and the burial-transit		resulting in coatti / Last	Due to (or as a conseq	uence of):							
687	physicate sthe	dlcal	•	d								
Вох (The law requires that the death certific tte has been signed by the attending p. bage 2 should be detached for use as t	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	ancy					224 D-4	6 -1-1	
m .	death e atte	iclar	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of d	I death 3 🗌	Ectopic pregna Other (specify)				23d. Date Mor	e of delivery ath Da	ay Year
0	at the de by the a tached	hys	9 Unknown	9□ Unknown		,						
S,	es that igned b	by P	Part II. Other significant conditions co		ulting in the un	derlying cause	given in Part I.		23e. Did tobac	co use contr	bute to the	cause of death?
D.C	w requir been si should I	ted	· DIABETES	NELLITUC					1 🗌 Yes	2 No	3 Probab	ly 4 Onknown
e C	law r las be	Completed	P*						24a. Was an autopsy	24b. V	Vere autops	y findings available letion of cause of
		Con							performe	d? d	eath?	No.
Vital Records,	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:					heck only one)			
ō	Phys r this ral dii	- To	1 Yes 2 No 27. Manner of Death	1 L Inpatient 2 L	ER/Outpatient 28b. Time of	3 DOA	Other: 4 🗆 Nurs	sing Home	5 Residence	e 6 □Othe	or (Specify)	
0	ding Ih. Tuner funer	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury		ljury at Vork? □ Yes 2 □ N	= 57	. Describe how	injury occurre	ed	
Division	after death Director: d in by the	Ifica	3 Suicide 6 Could not be	286. Place of Injury - At ho	ome, farm, stre				Location (Stree	nt and Numbe	er or Rural R	Toute Number
	el or s afte el Dir	Certification:	4 Homicide determined	building, etc. (Specifi	y)				City or Town, S	itate)		
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier Certifying Phy	vsician: To the best of my kno	wledge, death	occurred at the	time, date and	place, and	due to the caus	e(s) and mar	nner as state	ed.
	the H in 24 the F iplete	ledical	one)	iner: On the basis of examina and manner stated.	tion and/or inv	estigation, in m	y opinion, death	occurred a	at the time, date	and place, a	nd due to th	e cause(s)
	To	Σ	29b. Signature and title of certifier	Ά.	1.0	29c. Lice	ense number		29d	Date signed	(Month, Da	y, Year)
- (The last		your	10	VID	1	1600	16		1. 25.	CH	
			30. Name and address of person who c	ompleted cause of death (Item	1.23a) (Type, F	Print)	21-7=0		Le	1		121
	Sta	e	31. Date filed (Month, Day, Year)	32. Register's Signa	1(1.7)T	170300	C1/1 /63	//	TULY	VUCD)	/	VID
	Registra		JUL 2	ompleted cause of death (Item 32. Regist as Signa 3 2005	· K	fort	•					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** MARIE M. LOMAX JULY 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 109 RIVERSIDE ROAD **EDGEWATER** ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Director 579 28 9971 Yrs 78 WASHINGTON D.C. FEB.13,1927 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location item 27 is marked other then "naturel", or iteme 23a or 28e-f show other treumatic event, the Madical Examinar must be notified at 10d. Inside City Limits Directo 1 ☐ Yes 2 No MARYLAND ANNE ARUNDEL EDGEWATER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 109 RIVERSIDE ROAD death 21037 UNITED STATES by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other then "naturel", or itei 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. WHITE 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 **HOMEMAKER** HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be VETE CLEMENTS EDNA MINEBURG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANE M. DRAKE 7903 COLCHESTER COURT (DAUGHTER) PASADENA, MD. 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State ŏ permit. Page Department (Importent: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) LAKEMONT CEMETERY 07-19-05 DAVIDSONVILLE, MD. 21. Signatura Funeral Sprvice Lights 22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 2 2973 SOLOMONS ISLAND ROAD EDGEWATER, MD. 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed the attending physician and thed for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) Part II. Other significent conditions contributing to death but not resulting in he underlying cluse given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2∑ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death e Hospitel or Attending P 24 hours after death. e Funerel Director: After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospitel within 24 hours a To the Funerel D Kartifying Physician: To tyle best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature 29d. Date signed (Month, Day, Year) JULY 18,2005 person who completed cause of death (Item 23a) (Type 31. Date filed (Month, Day, Year) strar's Signature State Registrar

ORIGINAL

			For Stete Registrar	State of M	aryland / Dep <i>Ce</i>	artment of H		, ,	jiene	
	Physici		1. Decedent's Name (First, Middle, Las Patrycya Elayne	.,				2. Date of Dea Month 7-13-	th Day	Year G. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give	-		4b. City, Town, or	Location of Dea		4c. County o	5:20 P M
			Prince Georges (Community	Hospital	Cheverl			Prince	e Georges
	Funeral Director		5. Social Security Number 6. S	ex 7. Ag	ge (In yrs. last birthday, 58 Yrs.	Months Days	If Under 24 Hrs Hours Min		Year)	Birthplace (State or Foreign Country)
			578-66-2016 Usual Residence of Decedent	21	J0 ,			09-02	-46	Washington DC
	arylan show	'n	10a. State 10b. County DC		10c. City, Town or L					10d. Inside City Limits
	the M 28a-f	ecto	10e. Street and Number		Washin	gton 10f. Zip Code			l0g. Citizen of Wi	1 Yes 2 No
	h with	D	1911 Ridgecrest	Ct. SE		2002	0		USA	nat country?
	r deat	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Specify Yes or No-	14. Race	- American Indian,
36	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-1 show fre Medical Examirer must be notilled at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ If Yes, Give X Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:	,,	Specify:	
9	72 hou natura lical E	ted	15. Decedent's Ed (Specify only highest gra	lucation	16a. Dece	dent's Usual Occup	ation		16b. Kind of Bus	
21	vithin 7 ne. han "r	Completed	Elementary/Secondary (0-12)	College (1-4or	life.	kind of work done of DO NOT use retired Ninistrat:	1)	orking	Design	
g 5	filed w Hygie othar ti		12th 17. Father's Name (First, Middle, Last)		7101	iuriis caac		ime (First, Middle,	Priva	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If itiam 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic avent, the Medical Examiner must be notified at	To Be	James Edward Ll	oyd				Edwards	maiden cumame	,
lary	2 shorand Name	-	19a. Informant's Name/Relationship (•		ng Address (Street				
	of Health of Health itam 27 I	1	Rhonda Montague 20a. Method of Disposition	/ daughte	20b. Place of Disp	First St	reet SE	Washingto	n DC 20	032 City or Town, State
altimore,	Pages nent of I snt: If its ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specifi	Removal from State	cemetery, cre	matory or other place		-20-05	Clinton	
a E	permit. Pages Department of Important: If is any injury or o		21. Signature of Funeral Service Licen		/ /	2. Name and Addres				1 Services
œ	99 = 50		Estell-St	me of		500 Aller	ntown Rd	. Camp Sp	rings, l	MD 20748
b			23a. Part I. Enter the disease, of comp shock, or heart failure. List only Immediate Cause (Final	one cause on each II	ine.			,	est,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. ACUTE	a consequence of):	DIAL IN	FARCTIO	N		
	Examiner		Sequentially list conditions	b	a concequented on.					
	be isi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence of):					
	execut n and al-tran	Exam	that initiated events resulting in death) Last	cDue to (or as	a consequence of):					
8760,	icate be executed physician and s the burial-transit	dlcal	l	d						
9	ertifica ling ph	Med	IF FEMALE:							
Вох	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	
P.O.	that the de ed by the a detached t	hysi	1 □ Yes 2 🗖 No 9 □ Unknown	9☐ Unknown	tuno or doddi					
Records, F	sign d be	by	Part II. Other significant conditions on NON HODGKIN LY	ontributing to death b	out not resulting in the u	inderlying cause give	en in Part I.		_	bute to the cause of death? 3 Probably 4 XUnknown
ecc	law requires been a 2 should	Completed						24a. Was a		ere autopsy findings available for to completion of cause of
a E						-		perfor	ned? de	eath? ☐ Yes 2 ☐ No
Vital	aician certif irector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital:	ent 2 X ER/Outpatie	Othe		ath (Check only or		
Division of	Attending Phyaician: r death. actor: After this certific: by the funeral director,	n: To	27. Manner of Death	28a. Date of Inju	iry 28b. Time o	IL SEI DOX	at	Home 5 Reside	ence 6 LOther ow injury occurred	
Sior	tendin death. tor: Af the fur	catic	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆 '	Yes 2 □ No			
Ω	afte Dira	ertification;	4 Homicide determined	28e. Place of Inj building, et	ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (SI City or Town	reet and Number n, State)	r or Rural Route Number,
	To tha Hospital or Attent within 24 hours after death To tha Funaral Diractor: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best niner: On the basis o and manner st	of my knowledge, deat if examination and/or in ated.	h occurred at the tim vestigation, in my op	ne, date and plac pinion, death occ	e, and due to the curred at the time, d	ause(s) and manr ate and place, an	ner as stated. Indicate to the cause(s)
	To the Comp	Σ	29b. Signature and title of certifier	P		29c. License		2	9d. Date signed ((Month, Day, Year)
•			Veric	8 Can	_0	1 241			7-19	
•	Br. S.		30. Name and address of person who of DAYA SHARMA	completed cause of c	death (Item 23a) (Type,	Print)	WASHIN	IGTON, D	C 200	010
	Sta Registr		31. Date filed (Month, Day, Year) JUL 2 1 2005	32. Registr	ar's Signature			,		

Prysician Model Carolic Corin Levine As Facility Name (if not estissicing year street and number) As Facility Name (if not estissicing year street and number) As Facility Name (if not estissicing year street and number) As Facility Name (if not estissicing year street and number) As Facility Name (if not estissicing year street and number) As Facility Name (if not estissicing year street and number) As Facility Name (if not estissicing year street and number) As Facility Name (if not estissicing year street and number) As Facility Name (if not estissicing year street) As Facility Name (if not estissicing year street) As Facility Name (if not estissicing year street) As Facility Name (if not estissicing year street) As Facility Name (if not estissic City Units Name (if year street) As Facility Name (if not estissic City Units Name (if year street) As Facility Name (if not estissic City Units Name (if year street) As Facility Name (if not estissic City Units Name (if year street) As Facility Name (if not estissic City Units Name (if year street) As Facility Name (if not estissic City Units Name (if year street) As Facility				1 - State Amend Items#3 Registrar 1. Decedent's Name (First, Middle, Las		per PHY	Č ei	THE GAVE	S 8	19405	CC		3.11	200		25355
SA Sealty Roy Care ADVENTED TAIL SOURCE SEARCH CONTROL ADVENTED TAIL SOURCE SEARCH CONTROL ADVENTED TAIL SOURCE SEARCH CONTROL ADVENTED TAIL SOURCE SEARCH CONTROL ADVENTED TAIL SOURCE SEARCH CONTROL ADVENTED TAIL SOURCE SEARCH CONTROL ADVENTED TAIL SOURCE SEARCH CONTROL ADVENTED TAIL SOURCE SEARCH CONTROL ADVENTED TAIL SOURCE SEARCH CONTROL ADVENTED TAIL SOURCE SEARCH CONTROL ADVENTED TAIL SOURCE SEARCH CONTROL ADVENTED TAIL SOURCE SEARCH CONTROL ADVENTED TAIL SOURCE SEARCH CONTROL ADVENTED TAIL SOURCE SEARCH CONTROL ADVENTED TAIL SOURCE SEARCH CONTROL TO THE SEARCH CONTROL ADVENTED TAIL SOURCE SEARCH CONTROL TO TH	1											Month		2005	ar 3	r n
Some content of the	,							4b. City, Tov	vn, or L	ocation o	f Death	OULI				3.3011
Use Part Control				SHADY GROVE ADVEN	TIST HOSP	LTAL		ROCK	VIL	LE					IERY	
100. Start 100. Charty 1				577-60-8274							24 Hrs. Min.	8. Date of Bi (Month, D JANUAR	rth ay, Year Y 3,	⁹ 1945W	Birthplace Country) ASHT	e (State or Foreign NGTON, DC
College (14 of 5) SALES COUNTET PEANUTS COUNTET PEANUTS SALES COUNTET PEANUTS SALES COUNTET PEANUTS SALES COUNTET PEANUTS SALES COUNTET PEANUTS SALES COUNTET PEANUTS SALES COUNTET PEANUTS SALES		/land	į			10c. City, Tow	vn or Lo	cation							10d.	Inside City Limits
College (14 of 5) SALES COUNTET PEANUTS COUNTET PEANUTS SALES COUNTET PEANUTS SALES COUNTET PEANUTS SALES COUNTET PEANUTS SALES COUNTET PEANUTS SALES COUNTET PEANUTS SALES COUNTET PEANUTS SALES		a-feh	tor	MARYLAND MONTGO	MERY	R	OCK	/ILLE								1 Yes 2 No
College (14 of 5) SALES COUNTET PEANUTS COUNTET PEANUTS SALES COUNTET PEANUTS SALES COUNTET PEANUTS SALES COUNTET PEANUTS SALES COUNTET PEANUTS SALES COUNTET PEANUTS SALES COUNTET PEANUTS SALES		or 28	Dire	10e. Street and Number									10g. C			?
College (14 of 5) SALES COUNTET PEANUTS COUNTET PEANUTS SALES COUNTET PEANUTS SALES COUNTET PEANUTS SALES COUNTET PEANUTS SALES COUNTET PEANUTS SALES COUNTET PEANUTS SALES COUNTET PEANUTS SALES		s 23s	erai				140.1	_1			1.0.10					
College (14 of 5) SALES COUNTET PEANUTS COUNTET PEANUTS SALES COUNTET PEANUTS SALES COUNTET PEANUTS SALES COUNTET PEANUTS SALES COUNTET PEANUTS SALES COUNTET PEANUTS SALES COUNTET PEANUTS SALES	030	ursafterd al', oritem Exantiber	þ	1 ☐ Never Married 2 【 Married	Armed Forces? 1 ☐ Yes 2 2 N If Yes, Give						gin? (Spe , Puerto f	city Yes or N Rican, etc.)	0-	Black, V	Vhite, etc.	· ·
Physician //Medical Examiner Physician //Medical Examiner	5 - -	72 ho	eted			16a	. Deced	lent's Usual O	ccupatione du	on rina most	of working	na .	16b. i	Kind of Busine	ess/Indust	ry
Physician //Medical Examiner Physician //Medical Examiner		within ane. than	mpi		College (1-4or 5	+)	life. L	OO NOT use re	etired)			9	COL	TEMET E	E A MII	тc
Physician //Medical Examiner Physician //Medical Examiner	2	Hygie Hygie other I	e Co	17. Father's Name (First, Middle, Last)				DALES	1	8. Mothe	r's Name	(First, Middle	1		EANU	19
Physician //Medical Examiner Physician //Medical Examiner	rylan	nould be d Mental narked o	To B	HARRY GORIN	Deirel	10					S	ELMA				
Physician //Medical Examiner Physician //Medical Examiner	, Ma	and 2 sl ealth an m 27 is r		ROBERT LEVINE - H			1033	3 WINTE	ERGR	EEN	TERR	ACE, R	OCKV	ILLE,	MD 2	0850
Physician //Medical Examiner Physician //Medical Examiner	more	Pages 1		1 ☐ Burial 2 ☐ Cremation 3 ☐ I	Removal from State					ICE						
Physician / Medical Examiner By Septimer (actual Final Immediate Cause Final Immediate Final Immediat	nali Rali	permit. Departe Importe any inj		21. Signatura of Funeral Service Licens	99		22	EBBARDA EBBT RO	SRV	of Facility ILLE	UNER	AL RJR	₽ĢŦŦ	ON; M	^C 208	52
Due to (or as a consequence of): CLOSTRIDIUM DIFFICILE COLITIS Due to (or as a consequence of): CLOSTRIDIUM DIFFICILE COLITIS		Physician		Immediate Cause (Final	ne cause on each lin	θ.		er the mode of	dying,	such as	cardiac or	respiratory a	ırrest,		Inte	erval Between iset and Death
Due to (or as a consequence of): Due to (or as a consequence of):		/Medical			Due to (or as a	consequence	of):								4	DAIS
Due to (or as a consequence of): d. FFEMALE: 230. Was decedent pregnant in the past 12 months? 1 1 1 1 1 1 1 1 1		Examiner	_	Sequentially list conditions,				FICILE	COL	JITIS					4	DAYS
Due to (or as a consequence of): d. FFEMALE: 230. Was decedent pregnant in the past 12 months? 1 1 1 1 1 1 1 1 1		ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	of):									
Female: 23d. Date of delivery 23d. Date of Death (Check only one) 23d. Probably 4 Unknown 23d. Date of Death (Check only one) 23d. Date of Death (Check only one) 23d. Date of Death (Check only one) 23d. Date of Death (Check only one) 23d. Date of Death (Check only one) 23d. Date of Death (Check only one) 23d. Date of Death (Check only one) 23d. Date of Death (Check only one) 23d. Date of Death (Check only one) 23d. Date of Death (Check only one) 23d. Date of Death (Check only one) 23d. Date of Death (Check only one) 23d. Date of Death (Check only one) 23d. Date of Death (Check only one) 23d. Date of Death (Check only one) 23d. Date of Death (Check only one) 23d. Date of Death (Check only one) 23	,	execunand nand	Exar	that initiated events		consequence	of):								+	
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of Injury at Work? 29c. Certifier 29a. Certifier 29a. Certifier 29b. Signavare and little of certifier 29b. Signavare and little of certifier 29b. Signavare and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signavare and address of person who completed cause of death (Item 23a) Type, Print) CARL I. SCHOENBERGER, M.D., 16220 FREDERICK ROAD, GAITHERSBURG, MD 20877	g/01	ate be physicia the bur	ical		d											
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of Injury at Work? 29c. Certifier 29a. Certifier 29a. Certifier 29b. Signavare and little of certifier 29b. Signavare and little of certifier 29b. Signavare and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signavare and address of person who completed cause of death (Item 23a) Type, Print) CARL I. SCHOENBERGER, M.D., 16220 FREDERICK ROAD, GAITHERSBURG, MD 20877	0	ding p	/Med		23c If was outcome of	of preopancy	_						Ţ			
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of Injury at Work? 29c. Certifier 29a. Certifier 29a. Certifier 29b. Signavare and little of certifier 29b. Signavare and little of certifier 29b. Signavare and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signavare and address of person who completed cause of death (Item 23a) Type, Print) CARL I. SCHOENBERGER, M.D., 16220 FREDERICK ROAD, GAITHERSBURG, MD 20877	j.	the death by the atten ached for u	nysician	in the past 12 months?	1 Live birth 2 4 Pregnant at t	2 Fetal death									,	Year
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of Injury at Work? 29c. Certifier 29a. Certifier 29a. Certifier 29b. Signavare and little of certifier 29b. Signavare and little of certifier 29b. Signavare and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signavare and address of person who completed cause of death (Item 23a) Type, Print) CARL I. SCHOENBERGER, M.D., 16220 FREDERICK ROAD, GAITHERSBURG, MD 20877	'n	quires that en signed k uld be det	by						given	in Part I.						
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of Injury at Work? 29c. Certifier 29a. Certifier 29a. Certifier 29b. Signavare and little of certifier 29b. Signavare and little of certifier 29b. Signavare and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signavare and address of person who completed cause of death (Item 23a) Type, Print) CARL I. SCHOENBERGER, M.D., 16220 FREDERICK ROAD, GAITHERSBURG, MD 20877	Leco	The faw re te has ber age 2 sho	omplet	PULMONARY FIBROS	S							auto	psy ormed?	prior death	to comple	ition of cause of
27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury - At home, farm, street, factory, office 29a. Certifier (Check only one) 29b. Signature and dittle of certifier 29b. Signature and dittle of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARL I. SCHOENBERGER, M.D., 16220 FREDERICK ROAD, GAITHERSBURG, MD 20877	g		C						2	6. Place	of Death			1 1 1	res 2L	I No
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and dittle of certifier and mapping stated. 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARL I. SCHOENBERGER, M.D., 16220 FREDERICK ROAD, GAITHERSBURG, MD 20877	N TO UC	ing Ph h. After th funeral	မ	1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending	1 Inpatier		Time of	28c. I	Injury at Work?	t	28				Specify)	
D26540 JULY 15, 2005 30. Name and address of person who completed cause of death (Item 25a) (Type, Print) CARL I. SCHOENBERGER, M.D., 16220 FREDERICK ROAD, GAITHERSBURG, MD 20877	DIVISI		ertifica	3 Suicide 6 Could not be	28e. Place of Inju- building, etc.	ry - At home, fa (Specify)	arm, stre			3 2 11					Rural Ro	ute Number,
D26540 JULY 15, 2005 30. Name and address of person who completed cause of death (Item 25a) (Type, Print) CARL I. SCHOENBERGER, M.D., 16220 FREDERICK ROAD, GAITHERSBURG, MD 20877	_	e Hospita 24 hours e Funeral etely filled	O	2 Inducal Lamb	ner. On liperbasis or	examination an	e, death	occurred at the	e time, ny opini	date and	place, ar	nd due to the d at the time,	cause(s date an) and manner d place, and d	as stated	l. cause(s)
D26540 JULY 15, 2005 30. Name and address of person who completed cause of death (Item 25a) (Type, Print) CARL I. SCHOENBERGER, M.D., 16220 FREDERICK ROAD, GAITHERSBURG, MD 20877		To th within To th	Me	29b. Signature and title of certified	1/			29c. Lic	ense n	umber			29d. Da	te signed (Mo	onth, Day,	Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARL I. SCHOENBERGER, M.D., 16220 FREDERICK ROAD, GAITHERSBURG, MD 20877		4		or/	La Lore	Non	1		D26	5540			JŪ	JLY 15	, 200)5
				30. Name and address of person who care I. SCHOENBER	SER, M.D.,	ath (Item 23a)	FRE	Print) DERICK	ROA	AD, C	GAITH	ERSBUE	RG, 1	MD 208	77	
				31. Date filed (Month, Day, Year)												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Jul 28, 2005 Year **Physician** William Jr. McKay 8:00 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany 13511 McMullen Highway, SW Cumberland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Jul 27, **Funeral** Birthplace (State or Foreign Country) 1√2 M 2□F Months Days Hours Director <u>216-22-5037</u> Usual Residence of Decedent the Maryland show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or items 23e or 28e-f shov other treumatic event, the Mudical Extendrational by multified at MD Allegany Cumberland **Funeral Director** 1√ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 13511 McMullen Highway, SW 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Tes 2 No IVes, Give Year or Dates: WW II 1 Never Married Married Maryland 21215-0036 1 Yes 2 No Completed by Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Tire Builder Tire Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fill and Mental H Be Anna (Hendershot) McKav ပ္ Arthur B. McKav 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Ellsworth 213 Bowden Drive Fort Ashby WV 26719 Item 27 daughter Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages ō 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department of Importent: If eny injury or once. 7/31/2005 Cresaptown Scarpelli Funeral Home, PA * 4 □Donation 5 □Other (Specify) MD 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23at Part 1. Onter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ANCINOMA mount disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

| Compared to the compared 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No 2 No or Attending Physicien: director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? After 1 Natural 5 Pending investigation hours after death. М 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 Suicide in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funerel C

completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0000 D31875 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Welik, M.D.; 904 Seton Drive; Cumberland, MD 21502 AUG 0 3 2005 31. Date filed (Month State

DHMH 17 Rev 1/2001

·Registrar

		State of Maryland / Der	partment of Health and Mo	•	•	
		4 10	ertificate of Death		No.2005	25257
Physi	cian	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
/Med	lical	JUDY RUTH MERICA			27, 2005	
Exam	iner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death UPPER MARLBOR		4c. County of Deat	GEORGE'S
Funera		11201 MATTAPONI ROAD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	v) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		hplace (State or Foreign
Directo		205-30-6883 ^{1□M 2} AF 64 Yrs.	Months Days Hours Min.	(Month, Day, Ye MAR • 27		
land w.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
death with the Maryland ma 2?a or 28a-f show	tor	MARYLAND PRINCE GEORGE'S UPP	ER MARLBORO			1 ☐ Yes 2 🔀 No
th the)irec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Co	untry?
ath w	la l	11201 MATTAPONI ROAD	20772		U.S.A	
ter de	une	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☑ Married 1. Was Decedent Ever in U.S. 1. □ Yes 2 ☑ №	 Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R 	ify Yes or No- lican, etc.)	14. Race - Ame Black, White	
036 ours at	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes XXNo Specify:		Specify: WI	HITE
21215-0036 de within 72 hours aff giene. er than "naturai", or the Medical Exami	Completed by Funeral Director	(Specify only highest grade completed) (Given	pedent's Usual Occupation werking of work done during most of working	g 16t	o. Kind of Business/	Industry
within the Men	dmo	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		OF TAX II	N. F.
a filled other other.	Be C	17. Father's Name (First, Middle, Last)	MEMAKER 18. Mother's Name	(First, Middle, Mai	OWN H(den Sumame)	OME.
Vlar Menta M	To	GROVER CLEVELAND CRAMER	RUTH R	EBECCA	KAYLER	
Maryland Id 2 should be file the and Mentai Hy to is marked oth traumatic event	13		iling Address (Street and Number or Rural			
		20a. Method of Disposition 20b. Place of Dis	position (Name of Da	and the second second	R MARLBO	DRO, MD2077
Baltimorė, permit. Pages 1 ar Department of Hea important: if Item any Injury or other		1 🗆 Burial 2 Cremation 3 🗆 Hemoval from State	rematory or other place) IAN CREMATORY 7-2		,	
Baltil permit. 1 Departm Importal any inju		METROPOLIT.	22. Name and Address of Facility			LA, VA
a 88.588		Milul Bul	RAYMOND FUNERAL			
b .	1	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory affect. Approximate Interval Between Onset and Death Onset and Death				
Physiciar /Medica		Immediate Cause (Final disease or condition resulting in death)	MIC OAVOR			Weeks
Examine		Due to (or as a consequence of):				
, D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
60, be executed Iclan and burial-transit	Examiner	that initiated events C.				
3760, Sate be executed hysician and he burial-transit	calE	520 to (st 25 2 50150q201105 61).				
687 tificate g phys		d				
Box Bath cert attendin for use	an/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of del		•
O. E the dea by the at	/sici		Other (specify)		Month	Day Year
□ that debt	by Physician/Med	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Records, he law requires t e has been signe				1 🗆 Yes	2 No 3 □ Pro	obably 4 Unknown
Record le law requir has been si	Completed			24a. Was an	24b. Were au	topsy findings available completion of cause of
of Vital Re Physician: The lar this certificate has	Com			autopsy performed	death?	2 No
of Vital F Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death	,		
	5. To	1 ☐ Yes 2 2 ☐ No		e 5 Residence	e 6 □Other (Spec	sity)
ding ding Afte	ation	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation			injury occurred	
Division I or Attending after death. Director: Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office	Bf. Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
Division Hospital or Attended to the post after death Funeral Director: tely filled in by the						
DIVI To the Hospital or At within 24 hours after or To the Funeral Direc	edicai	29a. Certifier (Check only one) (Check only one) (Check only one)	ath occurred at the time, date and place, ar investigation, in my opinion, death occurred	nd due to the caus d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of centre	29c. License number	29d.	Date signed (Month	n, Day, Year)
•			D19431		1/27/05	
. 10		30 Name and address of person who completed cause of death (Item 23a) (Typ	779 / 1	11 Och	KAN SUN	21744
	tate	31 Date filed (Month Praye Year) 32 Bellietrar's Signature	W/A 105 77. W	Jest . Jest	()	00//
Regis		AUG 0 3 2005 Seren &	Sports.			

			1- State of Maryland / Department	artment of Health and Me	ental Hygien	000	25250
	Physici /Medic		1. Decedent's Name <i>(First, Middle, Last)</i> BETTY JEAN MIDGETT		2. Date of Death Month Da JULY 25	ay Year 2005	5:25 A M
	Examin	er	4a. Facility Name (If not institution, give street and number) 1200 JEFFERSON LANE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death WALDORF If Under 1 Year If Under 24 Hrs. 8		c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 M M M F 7. Age (In yrs. last birthday) Yrs. Usual Residence of Decedent	Months Days Hours Min.	B. Date of Birth (Month, Day, Year FEB • 16,) Cour	place (State or Foreign htry) A
	e-f show	Direc	10a. State 10b. County 10c. City, Town or Lot MARYLAND CHARLES WALDOR			1	0d. Inside City Limits
	ath with the 23e or 28		10e. Street and Number 1200 JEFFERSON LANE	10f. Zip Code 20601	10g. C	itizen of What Cour	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: if item 27 is marked other than "neturel", or items 23e or 28e-f show apply injury or other treumatic event, the M. deal Examinational Demolflind at once.	by Funeral	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric	ify Yes or No- can, etc.)	14. Race - Americ Black, White, Specify:	
Maryland 2	within 72 ho ene. than "netur ne M. dical	To Be Completed	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+) Give life.	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. F	Kind of Business/Ind	
	uld be filed Aental Hygir rked other tic event, t		12 HOM 17. Father's Name (First, Middle, Last) JAMES T. ADAMS	ELIZABET		OWN HO	ME
	and 2 should lealth and Men m 27 ie marke her treumatic		19a. Informant's Name/Relationship (Type, Print) BARNEY B. MIDGETT, JR.—SPOUSE	ng Address <i>(Street and Number or Rural F</i> 1200 JEFFERSON I	Route Number, City		
Baltimore,	it. Pages 1 rtment of H rtent: if ite njury or ott		'4 □Donation 5 □Other (Specify) METROPOLITIA	N CREMATORY 7-28	A salara	LEXANDR	•
Ba	permit. Departi Importi any inj		23a. Part1. Enter the disease, or complications that caused the death. Do rest ent	2. Name and Address of Facility RAYMOND FUNERAL LA PLATA MARYLA er the mode of dying, such as cardiac of r			Approximate
Records, P.O. Box 68760,	Physician JMedical Examiner transit sthe purial-transit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	TNOMA & CO	con.	×	Interval Between Onset and Death Onset and Dea
	that the death certific ed by the attending p detached for use as	Certification; To Be Completed by Physician/Me		∃Ectopic pregnancy ∃ Other (specify)		23d. Date of delive Month	ory Day Year
	w requires that been signed b should be deta		Part II. Dther significant conditions contributing to death but not resulting in the un	ndertying cause given in Part I.	23e. Did tobacco	use contribute to th	- 0
	ysicien: The law requisic certificate has been director, page 2 should		25. Was case referred to medical		24a. Was an autopsy performed?	prior to cor death?	psy findings available inpletion of cause of
	ding Ph I. After th funeral		examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien 27. Manner of Death 1 No Natural 5 Pending (Month, Day Year) 2 Accident investigation			6 ⊡Other (Specify	1)
DIX	oitei or Attendurs after death srel Director: illed in by the		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)		f. Location (Street a. City or Town, Stat	(e)	
	To the Hospitei or within 24 hours after To the Funerel Dir completely filled in	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death o	n occurred at the time, date and place, and stigation, in my opinion, death occurred	at the time, date an	s) and manner as st id place, and due to ate signed (Month, I	the cause(s)
	arl		30 Name and address of person o om, leted cause of death (Item 23a) (Type,	Print LANDIS	7 × ×	7/25,	105
	Sta Registr		31. Date filed (Month, Day Year) AUG 0 3 2005	W. WACOU			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No

4b. City, Town, or Location of Death

Mongold

2. Date of Death Month

Alsh Road, Cumberland, MO 21502

07

Year

05

4c. County of Death

17:25 AM

Physicia /Medic Examin	al
Funeral Director	

1 - For State Registrar

Delmar

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

Robert

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int If item 27 is marked other than "natural", or itams 23a or 28a-f show er than "natural", or itams 23a or 28a-f show It o Medical Examiner must be notified at

permit. Pages 1 and 2 a Department of Health ar Important: If item 27 is any injury or other trau once.

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

attending physician and tor use as the burial-transit The law requires that the death certiticate be executed as the been signed by the should be detached certificate this After thi

Division of Vital Records, P.O. Box 68760.

Examine Physician/Medical þ Completed To the Hospital or Attending Physician: Be 2 Certification: death. within 24 hours after deatl To the Funeral Director: filled in by

Hospital umberland Allegany Sacred teart If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours 1 M 2 □ F 232-26-1845 85 **Nov 20** Usual Residence of Deceden 10b. Count 10a. State 10c. City, Town or Location 10d. Inside City Limits Allegany MD Cresaptown Director 1 Yes 2 □ No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 14806 Vermont Avenue 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white þ WWII 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuaf Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coflege (1-4or 5+) owner/operator Del's Bowling Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John W. Mongold Myrtle (Mongold) Mongold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Myra Mongold wife 14806 Vermont Avenue Cresaptown MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Ashby Cemetery 7/30/2005 WV Fort Ashby * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility at Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death ALLURG CONGESTIVE Due to (or as a consequence of): EXUNTAY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 126907 JULY 28, 2005 Hellon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

.NAr 31. Date filed (Month

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registres Certificate of Death Reg. No.? I. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month DAVID PHILLIP MOWRY 15 2005 Ju₁y /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's 8400 Rhode Island Avenue College Park If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Aug. 9, 1932 Birthplace (State or Foreign Country) 1**X** M 2□ F Director 72 Yrs 520-30-3761 Kansas Usual Residence of Decedent 10a State 10h Counts 10c. City, Town or Location or 28a-f show 10d. Inside City Limits other traumatic avant, the Medical Examinar must be notified at Director 1X Yes 2 □ No MD Prince George's College Park 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? with Items 23a 8400 Rhode Island Avenue U.S.A. 20740 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any injury or other traumetic avant, the Medical Examination. Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 27 No 2 Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed. Elementary/Secondary (0-12) College (1-4or 5+) Archivist National Security Adm. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Glen Mowry Hallie Wooldridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11039 Willow Valley Road, Nevada City, CA 95959 Alan M. Mowry, Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 07/19/2005 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. onstance 4739 Baltimore Avenue, Hyattsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** MyDCardal disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by er (in idemio 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? perform certificate Division of Vital 2 No No No 1 Yes 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After Certification: 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 - Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 411-7 30. Name and address of person who complete use of death (Item 23a) (Type, Print) 14221 ark 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 2005

-48	849		F	Please 1						All Copies		egible.	
<i>-</i>		,	1 - For State Registrar			larylan	-	artment of F tificate of		d Mental Hy	giene Reg. No. 2	005	25261
	Physici /Medic		Decedent's Name (First, HERMINIO Me							2. Date of De Month July	Day 18, 20	Year	5:14 A ^M
1	Examir		4a. Facility Name (If not ins	titution, give	street and number	r)		4b. City, Town, o	r Location of D			unty of Death	2.1.1
			3212 Reed S					Glenar				nce Ge	
Ĺ	Funeral Director		5. Social Security Number None	-	M 2□F 7. A	lige (In yrs. Ii 26	ast birthday) Yrs.	If Under 1 Year Months Days		Aug • 1	ay, Year)	9. Birthp Cour 3 Guat	place (State or Foreign htty) cemala
	land ow		Usual Residence of Deceder 10a. State 10b. C			10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	the Man 28a-f sh notified	rector	Maryland Pr	ince (George's	G1	enarde	n 10f. Zip Code			10g Citizen	of What Cour	1 X Yes 2 □ No
	3a or	iO	3200 Reed S	treet.	Apt. 21	32		20706	á		_	ema1a	iu y r
	death	nere	11. Marital Status		12. Was Deceder	t Ever in U.S		Vas Decedent of H	lispanic Origin'	(Specify Yes or No	p- 14.	Race - Americ	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Marical Examination usat be multified at Once.	Completed by Funeral Directo	1 ☐ Never Married 2 ∑ 3 ☐ Widowed 4 ☐ Div	-	Armed Forces 1 □ Yes 2 ☑ If Yes, Give Year or Dates	No		Yes, specify Cub	Specify:	uerto Hican, etc.)		^{Black,} White, ^{ecify:} H i S]	
2-0	72 ho	etec	15. De (Specify only	cedent's Edu	cation e completed)		16a. Deced	lent's Usual Occup kind of work done	ation during most of	working		of Business/Inc	
121	within ne.	Idm	Elementary/Secondary (0		College (1-4o	r 5+)	lite. L	OO NOT use retire	d)	······································			
20	filed v Hygie ther t		6 17. Father's Name (First, M	liddle (Last)			Forei	nan	18 Mother's	Name (First, Middle	·		on Company
an	d be ental	To Be	Arturo Moso							elinda Ur		name)	
ary	shoul nd M mari	-	19a. Informant's Name/Rel	ationship (Ty	rpe, Print)		19b. Mailin	g Address (Street		r Rural Route Numb		wn. State. Zip	Code)
	alth a		Maria I. Vi	lleda -	- Spouse					pt. 2132,			
Baltimore,	of He of He fitern rothe		20a. Method of Disposition	ation 2 WE	lamavai fram Stat	20b. PI		sition (Name of natory or other pla		Date		on - City or To	
Ĕ	Pag ment ant: f ury o		1 ⊠ Burial 2-⊡ Crema 4 □ Donation \$ □ Ott		emoval from Stat	•		enterio Te	!	24/2005	_	a Guat	
Salt	permit. Departimport Import any inj		21. Signature of Funeral Se	ervice Licens	90		22	. Name and Addre	ss of Facility (Gasch's F	uneral	Home,	P.A.
_	40 E 8 9		tobus	70/1	Jan		4.	739 Balti	more A	ve., Hyat	tsvill		
	Physician /Medical Examiner		23a. Pani. Enter the disea shopk, or heart failure Immediale Cause (Final disease or condition resulting in death)	Elist only of	Due to (or a	hot w	ound	to ches		diac or respiratory a	rrest,		Approximate Interval Between Onset and Death
8760,	icate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or a Due to (or a	s a consequ					200		
P.O. Box 68	death certif e attending od for use a	Physician/Medic	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 Yes 2 No 9 Unknown	IFIL	3c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)	,		23d.	Date of delive Month	ry Day Year
	The law requires that the de ate has been signed by the c bage 2 should be detached	by	Part II. Other significant co	onditions cor	ntributing to death	but not resu	Ilting in the ur	nderlying cause giv	en in Part I.			7,7	e cause of death?
Division of Vital Records,	2 2	Completed								24a. Was auto perfo	psy prmed?	prior to cor death?	osy findings available npletion of cause of
/ita	cian: ertific	Be (25. Was case referred to m examiner?						26. Place of	Death Check on	one		
on of \	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	tion: To		Pending nvestigation	28a. Date of In (Month, D	jury ay Year)	ER/Outpation 28b. Time of Injury 4:55	28c. Injur Wor	4 🔲 14015111	g Home 5 Resi		curred	at scene
Divisi	for Atten after deat Director:	Certification:	3 ☐ Suicide 6 ☐ C	Could not be determined	28e. Place of I		me, farm, stre	eet, factory, office	7.00 Z.M.		Street and Ni	umber or Rura	Roug Num
	e Hospital 24 hours a e Funeral l etely filled	Medical Co	29a. Certifier 1 ☐ Ce (Check only one) 2 ☒ Me	rtifying Physical Exemi	sician: To the bes ner: On the basis and manner:	of examinati	wledge, death	occurred at the tir	ne, date and pl pinion, death o	ace, and due to the courred at the time,	cause(s) and	manner as st	ated
	To the within 2. To the Complet	Me	29b. Signature and title of o	ertifier	and manner:	ALAITOU.		29c. Licens	e number		29d. Date sid	gned (Month, i	Day, Year)
	- 2 - 0		> Las	MA	1000	Mn		0.C.	M.E.			19, 200	
41	N 4		30. Name and address of pr Tasha Z. Gr						Baltimo	ore, Maryl			
	Sta Registi		31. Date filed (Month, Day,			rar's Signat	ure	Sperile					
								/					

Physician (Radical Examiner Ralph E. Miller Ralph E. Miller Ralph E. Miller Ralph E. Miller Ralph E. Miller Goodwill Memonite Home Social Search Number (Free methodors, phe street and number) Goodwill Memonite Home Social Search Number 170–30–0954 170–30					State o	f Marylan	-	artment <i>rtificate</i>			and M	lental Hyg		_	
A Sealist Name (Fine Millor) and a seal for the seal of the seal o				1. Decedent's Name (First, Middle	Last)				0, 1				-/-	0.5	3 Time of Death?
4- Pecially Name of root installation, pive areast and number (Cococh vill Mermonitzed Home) Cococh vill Mermonitzed Home Cococh vill Mermonitzed Home Director 1. Social issuity Number 1. Toro-30—0954 1. Social issuity Number 1. Social issuity N				Ralph E. Mil	ler							Month	Day St	Year	2:30 pm
Second Security Number Sec				4a. Facility Name (If not institution,	give street and num	n <i>ber)</i>			4	b. City, To	wn, or Lo		4c. Count	303	a. sepin
Social Security Number Time Tim				Goodwill Mennor	ite Home					Grant	svil	le	Gar	rett	
Date Headers of Decodert 106. Size and Public Springs 106. Springs 106. Springs 106. Springs 106. Springs 106. Springs 107. Springs 108. Springs 10	Fune	eral			6. Sex				Year	If Under 2	24 Hrs.		Year)		ce (State or Foreign
100. City Town or Localition 100. In 100. City Town or Localition 100. In	Direc	ctor			163M 2LIF	95	Yrs.		Juyo	Tiodio		May 25,	1910	Grants	ville
ElementaryBecondary (b-12) College (1-for 5+) Compared to Co	and			*		10c Cit	tv. Town or Lo	ocation						100	d. Inside City Limits
ElementaryBecondary (b-12) College (1-for 5+) Compared to Co	/anyl	a pa	ō											100	1 ☐ Yes 2 🛣 No
ElementaryBecondary (b-12) College (1-for 5+) Compared to Co	the 1	Trough .	rect		ec	Spr	ings	10f Zin C	nde				10a Citizon of	What Country	
ElementaryBecondary (b-12) College (1-for 5+) Compared to Co	with Sa or	Š			ad									wriat Country	y :
ElementaryBecondary (b-12) College (1-for 5+) Compared to Co	death	T LOS	era		12. Was Dece	dent Ever in U	,S. 13.	Was Deceder	nt of H	ispanic Orig	gin? (Spe	ecify Yes or No-		ce - Americar	ı İndian,
ElementaryBecondary (b-12) College (1-for 5+) Compared to Co	or ite	TAILUR		1 Never Married 2 Marrie	d 1 ☐ Yes	2 X No		If Yes, specify	/ Cuba	n, Mexican	, Puèrto	Rican, etc.)			
ElementaryBecondary (b-12) College (1-for 5+) Compared to Co	ours (Exa	by	3 Nidowed 4 Divorced				1∟Yes 2Mg	Ø No	Specify:			Specif	^{fy:} Whit	:e
The second of th	72 hc	light.	etec	15. Decedent'	s Education		16a. Dece	dent's Usual (Occupa done o	ation	t of worki	na	16b. Kind of B	usiness/Indu	stry
Succession Part P	ارة ق القارق	8	npi			-4or 5+)					O WOIN				
Norman E. Miller Suie Hershberger Suie Hershbe	7 6 5 6	를	ပ္ပ	/			Owne	r/Opera	ato						quipment
19th Mailing Address (Steet and Number or Rural Rovee Number, City or Town, State, Zip Code, Print) 19th Mailing Address (Steet and Number or Rural Rovee Number, City or Town, State, Zip Code, Print) 19th Mailing Address (Steet and Number or Rural Rovee Number, City or Town, State, Zip Code, Print) 19th Mailing Address (Steet and Number or Rural Rovee Number, City or Town, State, Zip Code, Print) 19th Mailing Address (Steet and Number or Rural Rovee Number, City or Town, State, Zip Code, Print) 19th Mailing Address (Steet and Number or Rural Rovee, City or Town, State, Zip Code, Print) 19th Mailing Address (Steet and Number or Rural Rovee, City or Town, State, Zip Code, Print) 19th Mailing Address (Steet and Number or Rural Rovee, City or Town, State, Zip Code, Print) 19th Mailing Address (Steet and Number or Rural Rovee, City or Town, State, Zip Code, Print) 19th Mailing Address (Steet and Number or Rural Rovee, City or Town, State, Zip Code, Print) 19th Mailing Address (Steet and Number or Rural Rovee, City or Town, State, Zip Code, Print) 19th Mailing Address (Steet and Number or Rural Rovee, City or Town, State, Zip Code, Print) 19th Mailing Address (Steet and Number or Rural Rovee, City or Town, State, Zip Code, Print) 19th Mailing Address (Steet and Number or Rural Rovee, City or Other, State) 19th Mailing Address (Steet and Number or Rural Rovee, City or Other, State) 19th Mailing Address (Steet and Number or State, Zip Code, Other Address (Steet and Number or Giver Town, State, Zip Code, Print) 20th Mailing Address (Steet and Number or State, Zip Code, Print) 20th Mailing Address (Steet and Number or State, Zip Code, Print) 20th Mailing Address (Steet and Number or State, Zip Code, Print) 20th Mailing Address (Steet and Number or State, Zip Code, Print) 20th Mailing Address (Steet and Number or State, Zip Code, Print) 20th Mailing Address (Steet and Number or State, Zip Code, Print) 20th Mailing Address (Steet and Number or State, Zip Code, Print) 20th Mai	d ta b	949	Be	· ·	•									n <i>e)</i>	
Jane Benson/Daughter 20b. Method of Disposition (Name of Disposition (N	y ic y ic nould i Mer inerke	natic	ို				1								
20. Nethod of Disposition (Name of Disposition (Name of Disposition) (Name of Disposit	E 01 0 10	Ireun											_	_	rode)
The state of the	v - i = :	ther			ncer	20h F									· Ctata
21. Signature of Funery Service Licenses Provision Physician Phys	nt of	0		1 ☑ Burial 2 ☐ Cremation		siale				e)					i, State
Physician Modical Examiner Proposition Modical Examiner Proposition Modical Examiner Proposition Modical Examiner Proposition Proposition Modical Examiner Proposition Proposition Modical Examiner Proposition Propositi	it. P	<u>_</u>				Spr.				a of Facility	Ju	ly26,	prings	, PA	
Physician Medical Examiner	De min	once		▶ Waker	Deec	ma									, P.A.
Medical Examiner Medical Exa				23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that can't one cause on e	aused the deat ach line.	h. Do not ent	ter the mode of	of dying	g, such as	cardiac o	r respiratory arr	rest,	A	pproximate iterval Between
disease or condition resulting in death) The proposed of the property of the			i	Immediate Cause (Final	٨		0 -								Inset and Death
Sequentially list conditions process of the standard p			İ	disease or condition	a. Itci				T	ory	17	FILUR	E		HOUR.
Cause (Disease or Injury Introduced Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contribute to the cause (Disease or Injury			<u>a</u>		0 00		./\	1		6.				1	1. 0.0
Cause (Disease or Injury Introduced Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contribute to the cause (Disease or Injury	uted	ansit	ᇤ	On the state of th	■ bOV		1	3	4	121	Sec	cusu			year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1	exec an en	riai-tr	Exa	if any, leading to immediate cause. Enter Underlying	Dic	hot.	O O	A d o l	11	Hun				=	0000
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1	te be ysicia	ng ec	cai	that initiated events	c. '// C	Due to (o	r as a consec	ruence of):		1100)	,			3	, genos
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably				resulting in death) Last	<+	KoV co	3	,						1	month
The state of the s	th cell	ır use	an/		d. 01	10 L e									
The state of the s	e dea he att	ped fo	sici	Part II. Other significant condition	s contributing to de	ath but not res	ulting in the u	nderlying caus	se give	en in Part I.		23b. Did to	obacco use co	ntribute to th	ne cause of deeth?
The state of the s	at the	etaci	Phy	Angania								1□ Y	es 2□No	3 Probal	oly 4 Lunknown
The state of the s	res the	9		11.100010								-		T	
Composition of the control of the		should	oleted									24a. Was a perfor	in autopsy med?	availa	autopsy findings able prior to detion of cause ath?
Composition of the control of the	The la	sage :	E O									1 D Y	es 2⊠No		res 2□ No
Composition of the control of the	en: .	tor,		25. Was case referred to medical						26. Place	of Death	(Check only or	ne)		
Solicide Solicide Solicide Solicide Solicide Solicide Solicide Solicide Solicide Solicide Solicide	ysici is cel	direc	0		Hospital: 1 □ II	npatient 2	ER/Outpatier	nt 3 DOA	Othe	er: 4 Nur	rsing Hon	ne 5□Reside	ence 6 🗆 Oth	ner (Specify)	
Solicide Solicide Solicide Solicide Solicide Solicide Solicide Solicide Solicide Solicide Solicide	tert t	nera				of Injury h. Day Year)		f 28c.	. Injury Work	at					
	endir eath.	The t	atic	2 ☐ Accident investiga	ition		, ,	М			No				
	or Att	I in by	ertific	datami	led 286. Place			reet, factory, o	ffice		2			ber or Rural F	loute Number,
	Hospita 4 hours Funeral	tely filled		(Check only 2 Medical E	xeminer: On the ba	sis of examina	wledge, death	n occurred at t	the tim	e, date and	d place, a	and due to the c	ause(s) and ma	anner as state	ed.
	thin 2	E Ple	Med	one)	and mann	er stated.									
1 Computat Namay 0005 8650 4/21/05		ŏ		A A	1 1 _	Λ.					1 0-		D i A	C.	y, rour/
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1		ŀ	30 Name and address of same	J Nau	ually "	n 02e\ /T:	Drint'	CC	15 B	65)	7/21	105	
32 COV POVATE DR, GRANTSNIE MD Z 1536	U			0 1 1 - 1	A				15	36				r	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		Stai	е							ميا ميا					

DHMH 16 Rev 6/95

			For State Registrar	State of M	laryland	•	artment d <i>tificate</i>			and M		giene Reg. Nøs				
	0		Decedent's Name (First, Middle,	Last)							2. Date of De	ath (00	5	23. Time of	Dathi
	Physici /Medic		Leonardo	Hernandez	Mic1	at					Ju1v	Day 15	20	ear 0.5	5:15	D _M
	Examin		4a. Facility Name (If not institution,	give street and number;)		4b. City, To	wn, or	Location o		<u> </u>		county of		1 2.12	<u> </u>
			Shady Grove Ad	ventist Hos	spital		Rocl	kvi:	11e			М	ontg	ome:	ry	
	Funeral		,	5. Sex 7. Ag	ge (In yrs. las	t birthday)	If Under 1 \	Year Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da	th V Year)	9	Birthp	place (State or	r Foreign
	Director		213-06-5322	1201M 2LIF	73	Yrs.	Months	ays	Tiodis		Mar. 29		32 P	hil:	ippines	S
	and *	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, 1	fown or Lo	cation		· · ·						0d. Inside Cit	hr t imite
	/aryl	ō	Maryland Montg	omerv		kvi1								Ι.	1 ☐ Yes	
	28a-1	Director	10e. Street and Number		Roc		10f. Zip Co	nde				10g. Citize	on of M/h	24 Cour		
	with		13305 Midway A	wono				2085	. 1						,	
	ns 23	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. \				ain? (Spe	cify Yes or No		ited		ates can Indian,	
ယ	or Iter	Fur	1 ☐ Never Married 2X Marrie							, Puerto F	cify Yes or No Rican, etc.)		Black,			
ğ	72 hours after death with the Maryland naturel', or Items 23e or 28e-f show disal Examinat Franklik of al	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			I⊡Yes 2🛣	JNo	Specify:			5	Specify:	Fi.	lipino	
21215-0036	d within 72 hours after death with the Marylan jene. rithen "naturel", or ltems 23e or 28e-1 show the Medical Examinet mant be inclifted at	Completed	15. Decedent's (Specify only highest		1	16a. Deced	lent's Usual C	occupa	tion	t of workin	00	16b. Kin	d of Busin	iess/ln	dustry	
21	within ene. then "	ldu	Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	DO NOT use i	retired)	J. 1.1.9 11.000		.9					
	e filed within al Hygiene. other then vent, tre Me		12			Guar	d		40.14.4			Pris				
and	be filed at othe event,	Be	17. Father's Name (First, Middle, La Vincente Micla								(First, Middle les Her					
Ž	2 should be f and Mental H Is marked of raumetic ever	ဥ	19a. Informant's Name/Relationshi			10b Maife	a Address (C				Route Numb			Tr.	0.41	
Maryland	d2s than t7 Is		Flora Miclat /								ckvill					
ā,	Heal Heal tem 2		20a. Method of Disposition	W110	20b, Plac	e of Dispo	sition (Nama	of		D	ate				Wn, State	
Baltimore,	ages and of		1 X Burial 2 ☐ Cremation 3		9	-	natory or othe Memori				20,					
量	artme orter injur		21. Signature of Funeral Service Li		TGIR.					200 v DeV	ol Fun	KOCK	VILL	е,	Maryla	nd
B	permit. Pages 1 and 2 should be Department of Health and Monta Importent: If tiem 27 Is marked any injuring other traumetic a gnce.		De AN	Selle							Gaith				20877	
			23a. Palt1. Enter the disease, or c shock or heart failure. List of	omplications that cause	d the death.								-0,		Approximate)
	Physician		Immediate Cause (Final disease or condition	my one cause on each	Sel	0010									Interval Betw Onset and D	
	/Medical		resulting in death)	Due to (or as	s a consequer	nce of):								+		
	Examiner		Sequentially list conditions	b	rn	eun	nom	a								
	р ;	lner	Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exects)	b. Due to (or as	s a nonsequer	voa cit):	0.0		_							
	ecute and -trans	Examin	that initiated events resulting in death) Last				Car	100	1-							
8760,	cate be executed obysician and the burial-transit	E	100211111g 117 does 177 2201	Due to (or as	s a consequer	ice or): 🐃										
87	phy:	dlcal		d										_		
χe	death certifi e attending I d for use as	/Me	IF FEMALE:	23c. If yes, outcome	e of pregnanc	v						00	D-1			
Вох	atter I for u	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 ☐ Fetaf de	eath 3	Ectopic pregi Other (speci					2.5	3d. Date o Month		*	'ear
o.	at the de by the a tached t	Physiclan/M	1 ∐Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown			2 - 1113. (-)255.	.,,								
σ,	s that ned b s deta	by PI	Part II. Other significant condition	s contributing to death (but not resulti	ng in the u	nderlying caus	se give	n in Part I.		23e. Did t	obacco us	e contribu	ite to th	ne cause of de	eath?
Records,	quires in sign uld be										1 🗆	Yes 2□	No 3[☐ Prob	ably 4 U	Inknown
00	aw requir as been si 2 should	olete									24a. Was		24b. We	re auto	psy findings a	available
æ	he ha	Completed										rmed?	dea	ith?	mpletion of ca 2□ No	tuse of
Vital		Ø.	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes (Check only o	2. No		165	2 110	
f∨	nysic lis ce direc	To B	examiner? 1 ☐ Yes 25€ No	Hospital: Inpati	ient 2 EF	VOutpatien	t 3 DOA	Othe			ne 5∐Resi		Other	(Specif	y)	
n of			27. Manner of D th 1 DNatural 5 ☐ Pending	28a. ate of Inj (Month, Da	ury 28 ay Year)	Bb. Time of Injury	28c.	Injury Work	at	2	8d. Describe	how injury	occurred			
Sio	Attending r death. ector: After by the fune	catle	2 Accident investiga	ation			М	1 🗆 Y	es 2 🗆 l	No						
Division		Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	and 286. Place of In	njury - At home atc. <i>(Specify)</i>	e, farm, str	eet, factory, o	ffice		2	8f. Location (City or To		Number	or Rura	il Route Numb	ber,
	Hospitel or 44 hours afte Funeral Dire tely filled in b		00-0-47													
	To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best xeminer: On the basis of and manner s	or examination	and/or in	occurred at the vestigation, in	my op	e, date an inion, dea	d place, a th occurre	nd due to the id at the time,	date and p	nd manno place, and	ər as st I due to	ated. the cause(s)	1
	To the within 2 To the complet	Me	29b. Signature and title of certifier	10.		-	29c. L	icense	number	7.0		29d. Date	signed (/	Nonth,	Day, Year)	
	5		> ATK	2 July				YG	075	18		100	-4	15	, 20	05
	_		30. Name and address of person w	no completed cause of	death (Item 2	За) (Тура)	Print)	, -,	11.0	Pik	cate.	7	200	LL	rice	
					/		cor	LU			C TT Y	1	V	11)	205	17
	Sta Regist		31. Date filed (Month, Day, Year)	2005 33 Regist	trar's Signatur	Sept.	Will !									

			1 - For State Registrar	State of Ma	-	Department Certificate				giene Reg. D. []	N 5	25361	4
	Physici	an	1. Decedent's Name (First, Middle, Las	1)					2. Date of De		Year	3. Time of Dea	ith
	/Medic		Howard E.	Marrine	r Jr.				July	19	2005	0325	М
	Examin	er	4a. Facility Name (If not institution, give	//	1011	4b. City,	Town, or Loca	ation of Death	_	4c. Cou	unty of Death	10 0	
-	Eunaval		5. Social Security Number 6. Se	Medical 7. Aq	e (In yrs. last birt	hday) If Under	1 Year If U	Jnds 24 Hrs.	8. Date of Bir	th	WICOM!		reian
н	, Funeral Director		·	Z M 2□F		Yrs. Months	Days Ho	ours Min.	8. Date of Bir (Month, Da 5/5/1	y, Year) 947		lace (State or For try) Sylvania	
	pu >		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	and analisa							
	Aaryla r sho	៦	Maryland Wicomic	20		la Sprin	ac .					0d. Inside City Lir 1 ☐ Yes 2X	
	286-1	Director	10e. Street and Number		rarac.	10f. Zip				10a. Citizen	of What Coun		
	h with		23948 Taylors Tr	ail			21837			US		.,.	
	ems 2	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Deced		nic Origin? (Spe	ecify Yes or No	- 14.	Race - Americ Black, White,		
36	72 hours after death with the Maryland naturel', or Items 23e or 28e-f show Iteal Exambra must be natified at	by Fu	1 Never Married 2 Married	1 TXYes 2 □ !		1			r nour i otc.)		naihu -		
5-0036	72 hours "naturel", viical Ex.		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed			Decedent's Usua	I Occupation				WΩ of Business/Inc	ite	
215	_ = =	Completed	(Specify only highest gra-			(Give kind of world) life. DO NOT us	k done during	g most of worki	ng	TOD. KING C	7 00311633/110	iusti y	
2121	od within giene. er then "	E	Elementary/Secondary (0-12)	- College (1-401 :	· _	Agent				Insu	rance		
nd	be filed ital Hygis of other event, I	Be	17. Father's Name (First, Middle, Last)	_			18.	Mother's Name	(First, Middle	, Maiden Sur	mame)		
Maryland	Mer Mer Mer Mer Mer Mer Mer Mer Mer Mer	Jo	Howard E. Marrin		400	A4 35 A 7 A		lorence					
Mai	id 2 sho lth and 27 is ma treum		19a. Informant's Name/Relationship (7) Cora J. Marriner/			Mailing Address						,	
	1 ar Heal Bm 3		20a. Method of Disposition	wite	20b. Place of	1948 Tay Disposition (Nan	ne of	rail, M	ardela.	Spring 2 c. Locati	JS , MD on - City or To	21837 wn, State	-
E	0 = 5		1 Burial 2 Cremation 3 C 1 Donation 5 Other (Specify			y, crematory or or oury Crem		7/20	/05	Salie	sbury,	MD	
Baltimore,	permit. Pag Department Importent: any injury conce.		21. Signature of Funeral Service Licen	88	1-41100	22 Name an	d Address of	Facility	omo Dwo	foodi		sociatio	
_	82589	- 3	Mitted & Xt	wey (FSP					· · · ·	D 2180	SOCIATIO 4	n
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each li	I the death. Do r ne.	not enter the mode	e of dying, su	ich as cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death	1
	Pnysician /Medical	1	Immediate Cause (Final disease or condition resulting in death)		DIDM		THY	05			- 4	Onder and Death	
	Examiner		ſ		a consequence	77	2						
	1	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence	of):	a i L U	LE					
	cuted nd ransit	Examine	cause. Enter underlying Cause (Disease or injury that initiated events	· Rup	rren	of):	ic A	NOUNT	15m				
,00	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as	a consequence	of):							
8760,	ate hys the	dicai		d									
9 x	death certific e attending p od for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy					224	Date of delive		
Box	death atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No		2 Fetal death	3 □Ectopic pro 5 □ Other (sp				230.		Day Year	
P.0.	t the de by the a	hys	9 Unknown	9□ Unknown									
Ś	The law requires that the tee bas been signed by the bage 2 should be detache	by F	Part II. Other significant conditions of	ontributing to death b	ut not resulting in	the underlying ca	ause given in	Part I.				e cause of death	
Record	v requir been si should I	Completed							1 🗆	Yes 2□N	o 3∏Prob	ably 4 ∃Unkno	nwc
3ec	The law ate has b	mple							24a. Was autop		prior to cor	osy findings availa apletion of cause	able of
alF		1 -	as W						1 ☐ Yes	2 No	death? 1 🗌 Yes	2□ No	
Vital	sicie cer rect	o Be	25. Was case referred to medical examiner?	Hospital:	ent 2 ER/Ou	4		Place of Death			01 10 11		
of		⊢	27. Manner of Death	28a. Date of Inju (Month, Da		ime of 2	8c. Injury at	□ Nursing Hor	ne 5 ∐ Hesi 28d. Describe			7	_
ion	Attending In death.	atio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation		y rear) II	njury M	Work? 1 ☐ Yes	2 🗆 No					
Division	- 9 -	ertification:	3 ☐ Suicide 6 ☐ Could not be determined	280. Place of in	ury - At home, fa c. <i>(Specify)</i>	rm, street, factory	, office	1	28f. Location (City or To		umber or Rura	Route Number,	
	pitel o	O	One Continue 17 Continue D		-	4- 4							
	24 hc 24 hc e Fun etely 1	edical	29a. Certifier 1 Certifying Ph (Check only one) Medical Example (Check only one)	ysician: To the best iner: On the basis o and manner st	or my knowledge f examination an ated.	d/or investigation,	at the time, da in my opinior	ate and place, a n, death occurre	and due to the ed at the time,	date and pla	manner as st ce, and due to	ated. the cause(s)	
	To the Hospitel o within 24 hours aff To the Funerel Di completely filled in	Me	29b. Signature and title of certifier			290	. License nur	mber		29d. Date si	gned (Month,	Day, Year)	
	00)			042	107		JUL	Y 1'	7 200	25
,	7.3		30. Name and address of berson who	completed cause of c	leath (Item 23a) ((Type, Print) AR 011	1			nn			
	4	nte.	31. Date filed (Month, Pay Year)	2 /0	ar's Signature	NKOII	5/,	3,44156	ang n	110			
	Sta Regist		31. Date filed (Month, July 200)	2005	we &	Sparle	,						
	^	- 4	. <u></u>			-/-							

)		1- For Unpend Item Registrar	23a&27 per ili	end Apen Ce	artmens rtificate	t of He e of D	alth and eath	Mental H	ygien Reg. N		25365
Physic	ian	1. Decedent's Name (First, Middle, Las	t)					2. Date of D		ay Year	3. Time of Death
/Med			Creary		·			July	-		1624 P ^M
Exami	ner	4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or L	ocation of Dea	th	40	c. County of Dea	ith
Funeral		Fort Washington 1 5. Social Security Number 6. So 578–90–2647		rs. last birthday)	Fort If Under Months	1 Year	ington If Under 24 Hrs Hours Min	(Month, E	lirth Day, Year	Prince G	thplace (State or Foreign ountry)
		Usual Residence of Decedent	A	44				Aug.	10,	1900 1	Wash., DC
yland		10a. State 10b. County	10c.	City, Town or Lo	ocation						10d. Inside City Limits
Mar Mar	tor	Maryland Prince	George's		Ft.	Wash	nington				1 DXYes 2 □ No
or 28	Directo	10e. Street and Number			10f. Zip				10g. C	itizen of What Co	ountry?
death with the Maryland rms 23a or 28a-1 ehow rmust be notified at	at	6603 Eagle	way Lane				20744			Unite	ed States
intimore, Marylattic ZTZ 13-0030 int. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Health and Mental Hygiene. ortant: if item 27 is marked other then "natural", or items 23a or 28a-1 show injury or other traumatic event, the Medical Examinar must be notified at a.g	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Was Deced If Yes, spec		panic Origin? (S Mexican, Puer Specify:	Specify Yes or Note Rican, etc.)	10-	Specific	
72 ho	Completed	15. Decedent's Ed	ucation	16a. Dece	dent's Usua	I Occupati	on	. miles m. m	16b. H	Kind of Business	
within one of the within the within the wear	ple	(Specify only highest gra-	College (1-4or 5+)	life.	DO NOT us	e retired)	ring most of wo	rking			
nd 2121 e filed within al Hygiene. I other then vent, the Me	00	12th		Met	ro Tr	ansit	Emplo	yee		Priva	ite
Maryland Z nd 2 should be filed th and Mental Hygi 27 is marked other rtraumatic event, 1	Be (17. Father's Name (First, Middle, Last)				1	8. Mother's Na	me (First, Midd	le, Maidei	n Sumame)	
aryla should b nd Ment marked	2	Unknow	n					M	ildre	ed Mille	er
Marylan 2 should be 1 and Mental is marked raumatic ev		19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address	(Street and	d Number or R	ural Route Num	ber, City	or Town, State,	Zip Code)
ore, M es 1 and 2 of Health of Health of Hem 27 i		Joseph McCreary 20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □	201	5. Place of Dispo cemetery, cre	osition (Nam	ne of	Lane,	Ft. Wa		cton, MI location - City or	20744 Town, State
Pages Pages ment of ment of uny or o		4 Donation 5 Other (Specify	H:	armony M	lemori	al Pa	ark 7/3	0/2005	I	Landover	, MD
DAIKIMORE, permit. Pages 1 ar Department of Hea important: if Item eny injury or other		21. Signature of Funeral Service Licen	Slaval.	TT 2:						eral Hom sh., DC	
Physician		23a. Part 1. Early the disease, or comp shock, or heart failure. List only of Immediate Cluse (Final disease or condition	olications that caused the done cause on each line. Hypertensi						arrest,		Approximate Interval Between Onset and Death
pol ou, icate be executed by sicien and physicien and sthe burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a const. Due to (or as a const. Due to (or as a const.)								
death certif	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 Vunknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3	⊒Ectopic pre ⊒ Other (spe					23d. Date of de Month	livery Day Year
law requires that the as been signed by the 2 should be detached.	þ	Part II. Other significant conditions co	ontributing to death but not	resulting in the u	nderlying ca	use given	in Part I.			use contribute to	o the cause of death?
JUNISTION OF VICE THE COLUS, if or Attending Physician: The law requires I after death. Director: After this certificate has been signified by the funeral director, page 2 should be.	Completed							24a. Wa aut per 1 Xes	opsy formed?	prior to death?	utopsy findings available completion of cause of
Physician: The This certificate ral director, page	Be	25. Was case referred to medical examiner?						ath (Check only	one)		
Physi Physi this c	2	LA_ATes 2∐ NO		ER/Outpatier			4 Ituising r	lome 5 ☐ Res	sidence	6 ☐Other (Spe	cify)
Attending P r death.	ertification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1	28b. Time o Injury	f 28	3c. Injury at Work? 1 ☐ Ye	t s 2 □No	28d. Describe	how inju	iry occurred	
LIVISING TELE OF Attenues attenues de la Director: ed in by the	Certific	3 Surcide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)	reet, factory,	office		28f. Location City or To	(Street al	nd Number or Ri e)	ural Route Number,
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) 1 Certifying Phyone 2 Medical Example	ysician: To the best of my liner: On the basis of exam and manner stated.	knowledge, deat ination and/or in	h occurred a vestigation,	at the time, in my opin	date and place ion, death occu	e, and due to the urred at the time	e cause(s	s) and manner as d place, and due	s stated. to the cause(s)
To the within To the comple	Σ	29b. Signature and title of certifier			29c.	License n	umber		29d. Da	ate signed (Mont	h, Day, Year)
		> Caral H	Allan V	ud	0.	C.M.	E.		.Tu	ly 26, 2	2005
2		30. Name and address of person who c	completed cause of death (I		Print)			re, Mar			2009
St Regist	ate trar	31. Date filed (Month, Day, Year)	32. Registrar's Si								

State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Ethel L. 3:20 P M 2005 /Medical July 17 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

QQ Months Days Hours Min. 5. Social Security Number 6. Sex **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 213-42-7921 1 □ M 2 B F 88 Director Yrs March 23, 1917 Upper MarlboroM Usual Residence of Decedent with the Maryland 10a. State 10b County 10c. City, Town or Location 7 is marked other then "neturel", or Items 23e or 28e-f show treumatic event, I're Madical Examiner rust be notified at 10d. Inside City Limits Director MD Prince George's Upper Marlboro 1 ☐ Yes 2 RNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6409 Dowerhouse Road 20772 United States death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No 3 Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other then " Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles E. Moore Mary Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald E. Morag (Son) 6409 Dowerhouse Road Upper Marlboro, MD 20772 20a. Method of Disposition

Disposition
Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ö permit. Page Department of Importent: If any injury or once. Fort Lincoln Cem. 7/21/2005 Brentwood, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foneral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home /hom -11 3401 Bladensburg Road Brentwood, MD 20722 whom 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician verprovia disease or condition resulting in death) Ca Known /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Day 4 Pregnant at time of death Month Year 5 Other (specify) signed by the a t be detached for 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 2 1 No 2□ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 lapatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification; 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending hin 24 hours after death. the Funerel Director: After 1 Delural 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D wifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of a 2 29c. License number HUD son who completed cause of death (Item 23a) (Type, Print) 41 - Silver SPRI ol Georgia Ave 3 31. Date filed (Nonth Day, Year) 32. Registrar's Signature 2005 Registrar

i icas	se Type or Pr					-	_	noic.	
For State Registrar	State of r	Maryland / De C		cate of De			Iene ₃g. NØ ∏	0 =	2500-
1. Decedent's Name (First, Middle,	Last)					2. Date of Deat		U 3	S. Fine of Seath
WELDON AUSTIN	MEANS					July 1	Day	Vear 5	1:348
4a. Facility Name (If not institution,	give street and number	r)	4b.	City, Town, or Lo	cation of Death		4c. Coun	ty of Death	1
DOCTORS COMMUN	ITY HOSPIT	AT.		LANHAN	1		PRT	NCE C	EORGES
	S. Sex 7	Age (In yrs. last birtho		Inder 1 Year If	Under 24 Hrs.	8. Date of Birth		9. Birth	place (State or Forei
429 44 8849	XXM 2□F	7.5 Yr	s. Moi	nths Days I	Hours Min.	(Month, Day, OCT • 18	1929	COL	ANSAS
Usual Residence of Decedent						100-11-0		1 11111	IIIIDIID
10a. State 10b. County		10c. City, Town o	or Location	n					10d. Inside City Limit
MARYLAND PRINCE	GEORGES	MITCHEI	LVIL	LE					XX Yes 2□N
10e. Street and Number			10	f. Zip Code		11	0g. Citizen of	What Cou	intry?
3911 LOTTSFORD V	ISTA ROAD			20	721		HNTT	ED ST	'ATES
11. Marital Status	12. Was Deceder Armed Force		13. Was [Decedent of Hispa	anic Origin? (Sr	ecify Yes or No-	14. Ra	ce - Ameri	ican Indian,
1 Never Married 2 Marrie				, specify Cuban, N		nican, etc.)		ack, White,	
3 ☐ Widowed XX Divorced	Year or Dates	:	1 🗆 Y	es XIXINo S	Specify:		Spec	ity: BL	ACK
15. Decedent's (Specify only highest	Education	16a. D	ecedent's	Usual Occupation	n na most of word	ing	6b. Kind of I	3usiness/Ir	ndustry
Elementary/Secondary (0-12)	College (1-4c		te. DO N	OT use retired)	ng most or won	ing			
	4 YR	5. F	PESTI	CIDE SPE	CIALIST	2	FEDEI	RAL G	OVERNMENT
17. Father's Name (First, Middle, La	ast)			18.	. Mother's Nam	e (First, Middle, M	faiden Suma	me)	
BOURBON MEANS				I	UCY WII	LIE TOLE	:R		
19a. Informant's Name/Relationship	p (Type, Print)	19b. M	failing Add			al Route Number,		, State, Zij	p Code)
MARJORIE COLEMAN	N / SISTER			WARDS WA		ELPHI, M			
20a. Method of Disposition		20b. Place of D	isposition				Oc. Location		own, State
1 ☐ Burial XX Cremation 3 1 ☐ Donation 5 ☐ Other (Spe		9		N CREMAT	 OUX 7/9	1 /2005	A T T337 A	MDDT	
21. Signature of Funeral Service O									A, VA
1 7 7	Vlaush	l	MARS 4308	HALL'S F SUITLAN	ÚŇËRAL D ROAD	HOME OF SUITLA	MARYLA ND, MI	AND, II	NC. 46
23a. Part1. Inter the disease, or co shock or heart failure. List or	omplications that caus	ed the death. Do not	enter the	mode of dying, so	uch as cardiac				Approximate Interval Between
Immediate Cause (Final disease or Findition	MA/ 1	Caltil						11	Onset and Death
resulting in death)	a. Due to (or a	s a consequence of):		HKDIN	CDE	SKHA.	1411	1+2	
	NYI	$20 \times E$	~ I	n					
Sequentially list conditions, any, leading to immediate	b. Due to (or a	s a солзециенсе от:	()/						
tany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ACU	TE R	PIEC	PIRAT	nou	FAII	URI		
resulting in death) Last	C. Due to (or a	s a consequence of):		_/0(/) (U N 7	<u>' </u>	0130	- +	
	END	STALE	RI	ENAL	DISE	PACE			
	d.	311190		-10/12	0130	173C			
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnancy					004 0		
in the past 12 months?		2 Fetal death		oic pregnancy or (specify)				ate of delive onth	ery Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	at time of death	J D Ottie	(Specify)					-
Part II. Other significant condition	s contributing to death	but not resulting in th	e underly	ing cause given in	Part I	23e Did tob	acco use con	tribute to th	he cause of death?
	,		o diracily	ing oddso givoirii	11 01(1.				
						T Yes	2 □ No	3 Prob	pably 4 Unkriowr
						24a. Was an autopsy	24b.	Were auto	psy findings available
						perform		death?	
25. Was case referred to medical				26.	. Place of Deatl	(Check only one		03	-310
examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 Inpat	ient 2□ER/Outpa		Othor		ne 5 Resider	-		

Pnysician /Medical Examiner

27. Manner of Death

1 Natural
2 Accident

3 Suicide

4 Homicide

5 Pending

investigation

6 Could not be determined

Physician

/Medical

Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show enty injury or other traumatic event, Ir.e Mudical Examiner must be multified at once.

Baltimore, Maryland 21215-0036

Completed by Funeral Director

Be ٩

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached

Division of Vital Records, P.O. Box 68760,

CHANDRASEKHAR

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28a. Date of Injury (Month, Day Year)

29c. License number 52855

28c. Injury at Work?

M

1 Yes 2 No

29d. Date signed (Month, Day, Year)

07-18-2005

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KORAPATIM.D.

7207 HANOVER GREENBELT

28d. Describe how injury occurred

31. Date filed (Month, Day, Year)

JUL 2 1 2005 State Registrar

32. Registrar's Signature

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Mont 07 **Physician** LILLIAN E. MANNING 1:15 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MANOR CARE BETHESDA MONIGOMERY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0.3 (Months | Days | Days | 1997) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 578-68-6312 1□M 2/□F 56 **Director** WASHINGTON, Usual Residence of Decedent 10c. City, Town or Location WASHINGTON 10a. State 10b. County 10d. Inside City Limits or items 23a or 28e-f show other traumatic event, the Madical Examiner must be notified at DC Yes 2 No Director 10e Street and Number 10g. Citizen of What Country? U.S.A. 10f. Zip Code 20009 2420 16TH STREET N.W. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2X No Specify: þ Yes Give 3 ☐ Widowed 4 ☐ Divorced "naturai", Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) INFORMATION SPECIALIST permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene importent: If item 27 is marked other than any injury or other traumatic event, the Many injury or other traumatic event, the Many injury or other traumatic event, the Many injury or other traumatic event, the Many injury or other traumatic event. Elementary/Secondary (0-12) I.M.F. WORLD BANK Callega (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE E. MANNING EVELYN GAFNEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1534 ROXANNA RD. N.W. WASHINGTON, DC 20012 19a. Informant's Name/Relationship (Type, Print) GEORGETTA COX/ SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 □ Burial 2 🖸 Cremation 3 □ Removal from State Date 20c. Location - City or Town, State RIVERDALE PARK CREM. 7-20-2005 RIVERDALE, MD ^¹ 4 □ Donation 5 □ Other (Specify) neral Service Licensee 21. Signature of F 22. Name and Address of Facility JOHN $\, {
m T}_{ullet} \,$ RHINES COMPANY 3015 12TH STREET N.E. WASHINGTON, DC 20017 Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LEFT BREAST CANCER, METASTASIS TO BRAIN Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): EEP VEIN THROMBOSIS, PULMONARY EMBOLISM **Examiner** DEEP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trans Due to (or as a consequence of): P.O. Box 68760, death certificate be Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes XXNo Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death signed to Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSTON 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed CONGESTIVE HEART FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed? res 2 No DIABETES MELLITUS 1 ☐ Yes 2 No 1 Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital: Other: 0 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1X Natural 5 Pending hours after death. investigation М 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier D=20274 umber 29d. Date signed (Month, Day, Year) 7-17-2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KIRTI VOHRA M.D. 7710 BRADLEY BLVD, BETHESDA, MD 20817 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2005 Registrar

DHMH 17 Rev 1/2001

ADH UNKNOWN 05-4761 JAMES MYFRS

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink Freure All Copies Are Logible

		1 - For State Registrar 1. Decedent's Name (First, Middle)	le, Last)		Cei	rtificate	of Death		2. Date of De		005	9 G	Death.
hysicia /Medic xamin	al	James Richa	ard Myers	mber)		4b. City, To	own, or Location		Month JULY	14, Day 2	2005 County of Dea	1400	P ^N
neral	Ç1	112 CARROLL IS 5. Social Security Number	LAND ROAD 6. Sex	7. Age (In yrs. I	ast birthday)	MIDI	DLE RIVE	ER	8. Date of Bir	th	TIMORI	E thplace (State	or Foreig
ector		216-72-9620 Usual Residence of Decedent 10a. State 10b. County	1 √2 M 2□ F	44	Yrs.		Days Hours	With.	Dec 7,	1960	Mar	cyland	
268-1 SHO	Director	,	imore	100.01.9	, , , , , , , , , , , , , , , , , , , ,	10f. Zip Co	Middle	e Rive	er	10g Citize	n of What Co	1 ☐ Ye	s 250 N
ei, of itame 25a of 26a-1 snow Exeminer must be notified at	Funerai Dir	7318 Greenbar	12. Was Dec	edent Ever in U.	S. 13.1		212 nt of Hispanic Ori Cuban, Mexicar		cify Yes or No		USA . Race - Ame	encan Indian,	
Examinar	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	I If YAS, GI	2 XNo ve		1□Yes 2█	No Specify:				Black, Whit	te, etc. vhite	
is marked other than 'natura', 'aumatic event, the Medical Ext	Completed	15. Deceder (Specify only highe Elementary/Secondary (0-12) 12	nt's Education st grade completed) College (1-4or 5+)			Occupation done during mos retired) Chnician		ng		of Business		
c event, III	Be	17. Father's Name (First, Middle, Lawrence Mye.							(First, Middle Ley "Ur		,		
Imporant: if item 27 is marked any injury or other traumatic ev Quce.	То	19a. Informant's Name/Relations Deanna Myers,	ship (Type, Print)			_	Street and Number						
ry or othe		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 4 ☐ Donation 5 ☐ Other (S		State		osition (Name matory or othe Cremat			ate 3/2005		ition - City or	Town, State	
any inju		21. Signature of Fineral Service	nicensee	M00723		2. Name and A	Address of Facili Outh Mai	ty El	line Fu	neral	Home		
ician		Immediate Cause (Final disease or condition	a Mul	each line.	blunt	er the mode o	of dying, such as	Cardiac or	r respiratory a	rrest,		Approxim Intervat B Onset and	etween
dical niner succession of the control of the contro	cai Examiner	Immediate Cause (Final	a. Mur Due to b Due to	(or as a consequ	Solunt vence of):	and .	of dying, such as	Cardiac or	r respiratory a	rrest,		Intervat B	etween
dical and burial-transit	icai	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a	(or as a consequence of or as a consequence of pregnal pointh 2 □ Fetal anant at time of de	plunt vence of): vence of): vence of):	Ectopic pregi	shap 1	Cardiac or	r respiratory a	ries	d. Date of de Month	Intervat B On set and	etween
gred by the attending priystcian and in the attending priystcian and in the prival-transit in the prival trans	by Physician/Medicai	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	a. Multo Due to b Due to c Due to d 23c. If yes, ou 1 \[\left\] Live t 4 \[\text{Pregion} \] Pregion 9 \[\text{Unkn} \]	(or as a consequence of pregnation of the come of pregnation of the come of t	Divint vence of): vence of): vence of): vence of):	Ectopic pregi	shap 1	Force	o isp	23c	Month contribute to	Intervat B Onset and	etween d Death
as been signed by the attending prhysician and 2 should be detached for use as the burial-transit Laboratory	by Physician/Medicai	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	a. Multo Due to b Due to c Due to d 23c. If yes, ou 1 \[\left\] Live t 4 \[\text{Pregion} \] Pregion 9 \[\text{Unkn} \]	(or as a consequence of pregnation of the come of pregnation of the come of t	Divint vence of): vence of): vence of): vence of):	Ectopic pregi	shap 1	Force	23e. Did 1	23c cobacco use Yes 221 an approximat?	Month contribute to a contribute to a contribute to a prior to death?	Intervat B Onset and	Year I death? Unknows availal
this certificate has been signed by the attending physician and a line in a	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	a	(or as a consequence of pregnal and at time of decown	Divint vence of): vence of): vence of): vence of):	Ectopic pregi	inancy ify) 26. Place Other: 4 □ No.	e of Death	23e. Did to 1 = 24a. Was auto	23d tobacco use Yes 2 1 an psy primed? 2 \(\text{No} \) one) dence 6 \(\text{C} \)	Month contribute to No 3 Price to death? 12 Other (Spe	o the cause of robably 4 [utopsy finding completion of s 2 No	Year death? Unknow s availal cause of
this certificate has been signed by the attending physician and a line in a	Certification: To Be Compieted by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to b	(or as a consequence of pregnation to come of pregnation to come of pregnation to come of the come of	Lence of): Lence	Ectopic pregi	inancy ify) 26. Place Other: 4 \(\text{Nt} \) 2. Injury at Work? 1 \(\text{Yes} \) 2 \(\text{Z} \)	e of Death	23e. Did 1 1 24a. Was auto perfect only of the second of	230 cobacco use Yes 221 an psy ormed? 2 1 No cone) dence 6 1 bow injury of	Month a contribute to	livery Day o the cause of robably 4 [utopsy finding completion of s 2 No	Year Year Unkno
this certificate has been signed by the attending physician and a line in a	Certification: To Be Compieted by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Multipue to b. Due to c. Due to d. Service at the preging service	(or as a consequence of pregnal and at time of decown Inpatient 2 of fnjury At ho ing, etc. (Specify as a consequence of pregnal and at time of decown	Divint vence of):	Dectopic pregion of the course of the occurred at the occurred	26. Place Other: 4 \(\text{Nic} \) Injury at Work? 1 \(\text{Yes} \) 220 Office Cal Vert the time, date ar my opinion, dea	a of Death ursing Hom 2 No \$2	23e. Did to the sauto performance of the sauto	230 cobacco use Yes 221 an psy primed? 2 2 No pone) dence 6 2 how injury of both fluid Street and fluid cause(s) ar date and pl	Month a contribute to a contribute to a contribute to a contribute to a prior to death? A contribute to a contribute to a prior to death? A contribute to a contribu	Intervat B Onset and Onset	Year I death? Unknow S availa cause of
Is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Multipue to b. Due to c. Due to d. 23c. If yes, ou 1 Live to 4 Pregging 9 Unknown conscious unit to the light of the li	(or as a consequence of a consequence of pregna abirth 2 Fetal anant at time of decown Inpatient 2 of Injury At horing, etc. (Specify the best of my known assis of examination of stated)	ER/Outpatier 28b. Time of Injury 15th 115.	Dectopic pregion of the course	inancy ify) 26. Place Other: 4 \(\text{Nt} \) Injury at Work? 1 \(\text{Yes} \) 25 Office GIVEY	a of Death ursing Hom 2 No \$2	23e. Did to the sauto performance of the sauto	230 cobacco use Yes 221 an psy primed? 2 2 No pone) dence 6 2 how injury of both fluid Street and fluid cause(s) ar date and pl	Month a contribute to No 3 Pi 24b. Were an prior to death? 12 Yes A Other (Special Contribute of Recovered of Recover	Intervat B Onset and Onset	Year I death? Unknown s availai cause of

Regi DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	aryland	•	artment			and M	ental H	ygier Reg. N	00) =	250	7 (1
			Decedent's Name (First, Middle, Last,)							2. Date of I	Death	ay	Year	3. Time's	f Death	-
	Physici /Medic			lenholz							July	17,	2005	<u> </u>	2:52	a M	V
	Examin	er	4a. Facility Name (If not institution, give						Location o	of Death		4	lc. County				
			9610 Bellevue Dri 5. Social Security Number 6. Se		e (In yrs. la:	st birthday)	Bet. If Under	hesd 1 Year	a If Under 2	24 Hrs.	8. Date of E	Birth		tgom 9. Birthp	ery lace (State ltry)	or Foreig	gn
	Funeral Director			M 2 ₹ F	94	Yrs.	Months	Days	Hours	Min.	(Month, 2	<i>Day, Y</i> еа 2 2 ,]	911	Cour Indi	ana		
	pu k		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	cation							1	0d. Inside (City Limit	s
	Maryla f shot	ō	Maryland Montgom	orv	100. 0,	Beth										s 2 ⊠ N	
	r 28a-	Directo	10e. Street and Number	егу	l	Decii	10f. Zip	Code				10g. 0	Citizen of V	Vhat Cour	ntry?		
	th with		9610 Bellevue Dr	ive			20	814					US	A			
036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-1 show other than "natural", or items 23a or 28a-1 show event. It e Medical Examinar must be molified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			Was Deced If Yes, spec 1 ☐ Yes	ify Cuba	spanic Orion, Mexican Specify:	gin? (Spe i, Puerto l	cify Yes or I Rican, etc.)	Vo-	Blac	e - Americ k, White, Whi			
21215-0036	within 72 ho lene. 'than "natur 'te Medical I	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)			16a. Dece (Give life.	dent's Usua kind of wor DO NOT us	k done d	luring most	t of workii	ng	16b.	Kind of Bu	siness/In	dustry		
212	filed with Hygiene other the	Com		1		Hor	memak	er						Hom	e		
nd	be file	Be	17. Father's Name (First, Middle, Last)								(First, Midd	lle, Maide	en Sumam	е)			
Maryland	2 should be f n and Mental l is marked of raumatic eve	ဥ	Thomas Long 19a. Informant's Name/Relationship (T)	/pe, Print)		19b. Mailir	ng Address	(Street a		a Ha er or Rura	user I Route Nun	ber, City	or Town,	State, Zip	Code)		
	and 2 s ealth an n 27 is ner trau		Mary Margaret Mil		hter		-				esda,						
altimore,	Pages 1 anners of Heam		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		cer	ce of Dispo netery, crer of H	sition (Nan	ne of ther place	e) !	D	July 2 2005	20c.	Location -	City or To		rvla	nd
Balti	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service Licens	ee 6	'	22	Name and Franci 500 Ui	d Addres is J nive	s of Facilit Col rsity	lins Blv	Funerd, W,	ral	Home	Inc			
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each lir	ne.	Do not ent	er the mod	e of dying							Approxima Interval Be Onset and	ate etween	
	/Medical Examiner		disease or condition resulting in death)	Due to (or as			<u>iseas</u>	е									
	P =	ner	if any leading to immudiate	b. Due to (or as	a conseque	ence of):											
	cate be executed oblysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last	c. Due to (or as	a conseque	ence of):	-							=			
8760,	e be e sician e buria	dicai E		d													
9	rtificat ng phy as th	0	IEEE WE		17-25-7												
.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal d	leath 3	Ectopic production of the contract of the cont					-	23d. Dat Mor	e of deliventh	ery Day	Year	
<u> </u>	res that the de igned by the a be detached t	by	Part II. Other significant conditions co	ntributing to death b	ut not result	ting in the u	nderlying c	ause give	en in Part I.		1				ne cause of		n
Ö	w require been si should I	eted									24a. W		-		psy findings		
Il Records,		Completed				,,,					au pe	topsy rformed?	P	prior to colleath?	mpletion of	cause of	
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	200		(Check onl			/5 //			
n of	Attending Physician: r death. sctor: After this certificator, the funeral director.	on; To	27. Manner of Death 1. Natural 5 □ Pending	1 ☐ Inpatie 28a. Date of Inju (Month, Da		R/Outpatier 28b. Time o Injury	f 2	8c. Injury Work	at (?	- 2	me 5 X Re 28d. Describ				y)		
Division of	or Attendiater death Director: A	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuding, etc	ury - At hom c. (Specify)	ne, farm, str	M eet, factory		Yes 2□!	-	28f. Location City or 1	(Street		er or Rura	I Route Nui	mber,	
	oital or urs afte arel Dir					la da a da a				- 4			(-)				- =
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	edical	(Check only 2 Medical Examone)	iner: On the best and manner sta	fexamination		vestigation	in my of	pinion, dea			e, date a	nd place, a	and due to	the cause	(s)	
	To the To the complet	Σ	29b. Signature and title of certifier				290		number 026259	9			ate signed				
	6		30. Name and address of person who o	omploted control	7/	220/ / /	Print'	·				J	uly 1	18, 2	005		
			Ava Kaufman, M.D.					#10)3, B	ethe	sda. M	D 20	814				
	Sta	ate	31. Date filed (Month, Day, Year)	Sen Danieta	ada Cimpoti								7 4 5				
	Regist	rar	JUL 19 200	Some .	JF	438	SCI										

		For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of H <i>rtificate of L</i>			ene g. Not) A A C	
		Decedent's Name (First, Middle, Las	1)				2. Date of Death	2003	3. Tuhe d Dia
Physicia /Medic		Carlos A.		Matus			July 16	Day Yea , 2005	″ 11:30 ⁶
Examine	er	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Deat	h	4c. County of De	eath
		11814 Tifton Driv		(In yrs. last birthday)	Potom If Under 1 Year	ac If Under 24 Hrs.	8. Date of Birth	Montgo	
Funeral Director			M 2□F /. Age	64 Yrs.	Months Days	Hours Min.	Month, Day, Aug. 7,		Birthplace (State or Fo. Country) .Caragua
death with the Maryland ms 23a or 28a-f show		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Li
the Marylar 28a-f show	tor	Maryland Montgom	erv	Potoma	C				1 ☐ Yes 2 💆
or 28s	lrec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
23a c	alD	11814 Tifton Dri	ve		20854			USA	
urs after alt, or Ite	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	0	Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 ☐ No	spanic Origin? (S n, Mexican, Puerl Specify! Nica	pecify Yes or No- o Rican, etc.) araguan		merican Indian, hite, etc. ite
within 72 hours ene. than "natural", ne Medical Exa	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	(e completed) College (1-4or 5-	(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	luring most of wor	rking 1	6b. Kind of Busines	
Hygi ther	ပို	17. Father's Name (First, Middle, Last)	4	Rea	ltor	18. Mother's Nar	ne (First, Middle, M	Real Est	ate
ked c	To Be	Carlos Matus							
mari mari	Ě	19a. Informant's Name/Relationship (T	/pe, Print)	19b. Mailir	ng Address (Street a	Lila U		City or Town. State	Zin Code)
1th a 27 is r trau		Joan L. Matus/ Wi	fe		14 Tifton				
penint. ragges i arro a should be insulated when the population of Health and Mental Hygene. Important: If item 27 Is marked other than any injury of either traumatic event. If a M. once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I '4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	20b. Place of Dispo cemetery, crer	sition (Name of natory or other place aven Cemeter	Ju	Date 2 1y 20,	Oc. Location - City	
Departmen Departmen Important: any injury once.		21. Signature of Funeral Service Licens	ils-	22 F: 50	Name and Address rancis J. 00 Univers	s of Facility Collins	Funeral	Home Inc	ng, MD 209
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ications that caused ne cause on each line	the death. Do not ent					Approximate Interval Betwee
nysician		Immediate Cause (Final disease or condition		Cirrhosis					Onset and Deat 5 Years
/Medical xaminer		resulting in death)	a	consequence of):					J Tedis
inicate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause that initiated events resulting in death) Last	o	consequence of):					
e attendir	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t 9 Unknown	Petal death 3□	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
been signed by th	ed by P	Part II. Other significant conditions co Hepatoma	ntributing to death bu	t not resulting in the ur	nderlying cause give	n in Part I.			to the cause of death Probably 4 DUnkn
O.S.	Completed by						24a. Was an autopsy perform	prior to ed? death?	autopsy findings avai completion of cause as 2 No
this certific	Be	25. Was case referred to medical examiner?	lospital:		Other		th (Check only one		
within 24 hours after death. To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2	ation: To	1 ☐ Yes 2 Å No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	1 ☐ Inpatien 28a. Date of Injury (Month, Day	28b. Time of	28c. Injury Work	4 Nursing H	ome 5 🔀 Residen 28d. Describe how		pecify)
rs after death	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc.				City or Town,	State)	Rural Route Number,
within 24 hours after To the Funeral Director completely filled in I	Medical	29a. Certifier 1X Certifying Phy (Check only one) 1 Medical Exami	sician: To the best of ner: On the basis of e and manner state	i my knowledge, death examination and/or inv ed.	occurred at the time estigation, in my opi	e, date and place inion, death occu	, and due to the cau rred at the time, dat	se(s) and manner a e and place, and du	as stated. ue to the cause(s)
omple	Φ -	29b. Signature and title of certifier			29c. License	number	290	d. Date signed (Mor	nth, Day, Year)
7) At			D52	2382		uly 18, 2	,
		30. Name and addres Danilo Molieri,	M.D. 470	ath (Item 23a) (Type, I 1 Randolph	Print) Road, #1	01, Rock	sville, M	20852	
State Registra	-	31. Date filed (Month, Day, Year)	327 Registrar	's Signature	de				

		-	For State Registrar	State of M	laryland / Dep Ce	artment of F		Mental Hy	giene	2000	25	270
			1. Decedent's Name (First, Middle, Las	st)				2. Date of D		Van	3. Time o	of Death
	Physicia /Medic		Carol Ann McCelv	ev				July	Day 13, 2	.005	2:04	P M
	Examin	_	4a. Facility Name (If not institution, give	street and number	r)	4b. City, Town, o	r Location of Dea	ath	4c.	County of Death		
			Montgomery Villag			Gaither				ntgomer		
	Funeral Director		219-64-6039	ex 7. A □ M 2☐XF	sge (In yrs. last birthday)	Months Days	Hours Mi		71952	9. Birth Cou Texa	place (State intry) S	or Foreign
	and w	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside C	City Limits
	Aaryli f sho	ō	Maryland Montgome	rv	Gaithers	hurg					1 XYes	s 2∐No
	the 288-	Funeral Director	10e. Street and Number	- 7		10f. Zip Code			10g. Citi	zen of What Cou	intry?	
	3a or	Ö	9501 Tunstall Pla	CE		20886			USA			
	death ms 2	nera	11. Marital Status	12. Was Deceden	nt Ever in U.S. 13.	Was Decedent of H	lispanic Origin?	(Specify Yes or N		14. Race - Ameri Black, White		
ထွ	or its	Ī.	1 ☐ Never Married 2 ☐ Married	1 Tes 2 T		1 ☐ Yes 2 No	Specify:	nto moan, etc.)				
9	172 hours after death with the Maryland "natural", or Itams 23a or 28a-f show calcal Examinat must be notilled at	d by	3 ☐ Widowed 4 X Divorced	Year or Dates						7111	ite	
5	"nati	iete	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of w	rorking		nd of Business/li lercial	,	or
21215-0036	filed within Hygiene. Ither than "unt, It e Mag	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)	igner	-7			Desi		02
d 2	be filed within 72 ho tal Hygiene. d other than "natu event, the Modical	Be C	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle	, Maiden			
<u>lar</u>	should be fand Mental I	To B	Robert Lee McCelv	ey			Sydney	Vallenty	yne			
Maryland			19a. Informant's Name/Relationship (7	Type, Print)		ing Address (Street					p Code)	
	2 ± 2 ± 2		Sydney Vallentyne	/ Mother		Hillmead	e Road 1	Bowie, MI			Chata	
Baltimore,	Pages 1 ar nent of Hea int: If Itam iry or otha		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐	Removal from Stat	.0	matory or other place				cation - City or T	own, State	
Ë	t. Pa rtmen rtant: njury		* 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Light	y) 1000 =	Huntt Cre	ematory 2. Name and Addre		5/2005		orf, MD	al Hom	10
Ba	permit. Pages 'Department of H Important: If Its any Injury or of		21. Signature of distance of the	1330		16000 Ann					ar nom	
			23a. Part1. Enter the disease, or comp	plications that caus	ed the death. Do not en					3 20713	Approxima Interval Be	
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each		7 Cox	MBLL	Down			Onset and	Death
	/Medical		resulting in death)	Due to (or a	is a consequence of):	1600	16600	-Colle				
	Examiner		Sequentially list conditions.	b								
	ad sit	Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause, Olisease or injury	Duato (or a	is a consequence of):							
	and and I-tran	хап	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	is a consequence of):							
8760,	icate be executed physician and s the burial-transit	dicai E		,	, ,							
687	ificate g phys as the	0		d								
ŏ	leath certific attending pl	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		□Ectopic pregnancy	,			23d. Date of deliv		V
B.	ne deat the att hed for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of death 5 [Other (specify)				Month	Day	Year
P.0	that the d ed by the detached	Phy	9 ☐ Unknown Part II. Other significant conditions c	antichuting to dooth	but not regulting in the	underhing equae cit	on in Part I	23a Did	tobaccou	se contribute to	the cause of	death?
ds,	ogu as	d by	Part II. Other significant conditions c	oninbuting to death	but not resulting in the t	andenying cause giv	en m raiti.			No 3□Pro		Unknown
Record	w require been signatures	Completed						24a. Wa:	s an	24b. Were aut	onsy findings	s available
Re	The lav	ф						auto perf	opsy ormed?	prior to co	ompletion of	
Vital		ပိ	25. Was case referred to medical				26. Place of D	ath (Check only	2 No	1 🗆 Yes	2 No	
\leq	Physician: this certific ral director,	O B	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpa	tient 2 ER/Outpatie	int 3□ DOA Oth	оп .	Home 5 ☐ Res		6 □Other (Spec	ify)	
n of		Ju: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of In	njury 28b. Time o	of 28c. Injur Wor	y at rk?	28d. Describe	how injur	y occurred		
Sio	Attandie death. ctor: Al y the fu	catic	2 Accident investigation				Yes 2 □ No					
Division	i or Attand after death Diractor: ,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	288. Place of 1	njury - At home, farm, st etc. <i>(Specify)</i>	reet, factory, office			(Street an own, State	d Number or Rui)	ai Route Nur	mber,
	To the Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: Afte completely filled in by the fune				st of my knowledge, dea of examination and/or in							(c)
	the H ain 24 tha F tha F	Medical	one)	and manner				carred at the thire				
	To To com	2	29b. Signature and title of certifier		1	29c. Licens		100		e signed (Month	-	
,				NX	\sim Λ	1. CE	2051	7.00	-+-	14-70	07	
						D : 0						
			30. Name and address of person who		/		70 5114	201 Ba-	1-1-1	lo MD 9	0.050	
	Sta	te.	30. Name and address of person who Anushiravan Dadgar 31. Date filed (Month, Day, Yasr) 20	r, 9715	d death (flem 23a) (Type Medical Ce strar's Signature		ve Suite	201 Roc	kvil	le, MD 2	0850	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year Mary Louise Miller July 9, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Convalescent & Rehab. Crofton Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days Months Hours Min 1□ M 2 🗐 Director 214 01 2718 March 24,1917 West Virginia 88 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits ust be notified at 1 ☐ Yes 2 ☐ No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 2004 Elmwood ROAD 21402 Funeral United States or itams 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 7 is markad othar than "natural", or itams traumatic evant, If a Modical Exeminer 11. Marital Status Race - American Indian, Black, White, etc. filed within 72 hours after □Yes 2V No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ⊉CXNo Specify: þ Specify: White 3 Widowed 4 □ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. markad othar than Elementary/Secondary (0-12) College (1-4or 5+) 0 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f nent of Health and Mental I int: If itam 27 is markad o ပ George Gerkin Mary Louise Goeke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If itam 27 is or othar trai Betty C. Hayes (Daughter) 2004 Elmwood Road Annapolis, MD. 21402 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Department of Important: If any injury or once. Glen Haven Cemetery 107-15-05 Glen Burnie, MD. 22. Name and Address of Facility

George P. Kalas Funeral Home Ser ce Licens 21. Signature of Funding 2973 Solomons Island Road, Edgewater, Md. 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician 49 bisther Mumory /Medical (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner onsequence of) burial-transit To tha Hospital or Attsnding Physician: The law requires that the death certificate be executed 40 Box 68760. IF FEMALE 9SN 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.0 detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 1 TYes 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑No page 2 s 2 **X** No 1 ☐ Yes the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Cther: 4 vursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 ☑ No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide filled within 24 hours a To tha Funaral C 29a. Certifier i 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title 29d. Date signed (Month, Day, Year) Mighway Southwest Olin Burnie 2106) of death (Item 23a) (Type, Print) 208 31. Data filled (Month, Day, Year) State Registrar

			1 - For State Registrar		f Maryland /	Departr		lealth and I		_	25374
	Physic	ian	Decedent's Name (First, Middle, La	st)					2. Date of Deat Month	Day Ye	3. Time of Death
	/Medi		Dominik B	ryan	Newsome				July	14, 20	05 6:20P M
	Exami		4e. Facility Name (If not institution, give			4b.	City, Town, o	or Location of Deat	h	4c. County of D	
			Civista Medi		nter		La	Plata		Charl	es
	Funeral		5. Social Security Number 6. S	M 2□F	7. Age (In yrs. last be		Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign Country)
	Director		N/A	M 2□F		Yrs.	onths Days	2 36	8. Date of Birth (Month, Day, July14	2005	Maryland
	D		Usual Residence of Decedent						10	, = 0 0 5	riar y rand
	how	١.	10a. State 10b. County		10c. City, Tov	vn or Locatio	n				10d. Inside City Limits
	Ma-1-8	į	MD Char	les	Br	yans	Road				1 ☐ Yes 2 📆 No
	r 28	ire	10e. Street and Number				Of. Zip Code		10	g. Citizen of What	Country?
	h wit	0	6516 Jessica C	ourt			2061	6		USA	
	death with the Maryland ms 23a or 28a-f show	Funeral Director	11. Marital Status		edent Ever in U.S.	13. Was I			pecify Yes or No-		merican Indian,
(0	r Ite	Ē	1 XNever Married 2 ☐ Married	Armed Fo 1 ☐ Yes	2 X No			lispanic Origin? (S an, Mexican, Puert Me	377 0 0 00	Black, W	
8	urs a	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or D	/e ates:	1 X 1 Y	res 2□No	Specify: P11er	to Rica	Specify:	white
21215-0036	2 ho	Completed	15. Decedent's E	ducation	16a	. Decedent's	Usual Occup			6b. Kind of Busine	
2	n 7	pie	(Specify only highest gra		455.	(Give kind life. DO N	of work done IOT use retire	during most of word)	rking		,
77	with	Eo	Elementary/Secondary (0-12)	College (1	-40r5+)	nev	rer wo	rked			
	Hyg Hyg other	O	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, M	laiden Sumame)	-
ä	d be antai ced c	To Be	Donald Bryan		e				a Maria		
2	houl d Me mark mati	Ĕ	19a. Informant's Name/Relationship (h Mailine Ad	drass /Strast				7. 0
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other treumatic event. Ite Madical Examiner must be notified at ance.		Donald Newsome	/Fathe	r	6516	Jessi	and Number of Hu	ral Route Number. Bryans	Post MD	a, Zip Code) 20616
a)	tealt			, 1 4 5110.					The second	-	
Baltimore,	Jes I of h		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐	Removal from	State 200. Place of cemete	ory, cremator	(Name of y or other plac	ce)		Oc. Location - City	
Ē	Pa men ent: ury		`4 ☐ Donation 5 ☐ Other (Special		St.	Peter	s Cem	etery 7	/20/05	Waldorf	,Maryland
a	permit. Depart Import eny inj		21. Signature of Suneral Service Licer	1588	M00945	22. Nas	ᠬ ᠣ᠘ᠰᡏᡏ	SS OF FINT C	FUNERA	LUOME	D A
m	89 2 2 8		h Javes C	. Tchi	ak)	D		-ECHULS	LA PLAT	L HOME,	F.A.
			23a. Part1. Enter the disease, or com	plications that c	aused the death. Do	not enter the	mode of dyin	g, such as cardiac	or respiratory arre	A,MD ZU	Approximate
	11 115		shock, or heart failure. List only Immediate Cause (Final								Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)		1-1 dist						
	Examiner		•	Due to (or as a consequence	of):					
		<u>_</u>	Sequentially list conditions,	b. — Buo to /	or as a consequence	of).					
	ed	į	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D00 10 (or as a consequence	Ol).					
	and and -trar	Examiner	that initiated events resulting in death) Last	C. Dun to /	or as a consequence	-4)-					
8760,	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit			Due to (or as a consequence	oi).					
87	hysie the t	Physician/Medical		d							
9	that the death certifica ed by the attending pl detached for use as t	Med	IF FEMALE:								
Вох	th ce tendi	an/l	23b. Was decedent pregnant		come of pregnancy irth 2 Fetal death	3 □Ector	pic pregnancy	,		23d. Date of	delivery
	dea he at	sici	in the past 12 months? 1 Yes 2 No	4□Pregna	ant at time of death		or (specify)			Month	Day Year
P.0	t the by th tache	hys	9 Unknown	9□ Unkno	own						
	res tha igned be det	by P	Part II. Other significant conditions of	ontributing to de	eath but not resulting i	n the underly	ring cause give	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?
ğ	auire n sig ald b	D P							1 ☐ Yes	2 X No 3□	Probably 4 Unknown
of Vital Records,	w require been sign	Completed							24- 145	045 145	
3e	has has	шр				-			24a. Was an autopsy	prior t ed? death	autopsy findings available o completion of cause of
		ပိ							1 X Yes 2		
/its	Physiclen: this certific ral director,	Be	25. Was case referred to medical examiner?	Us - hat					th (Check only one		
=	dis dis	2	1 ☐ Yes 2X No		npatient 2 ER/Ou	tpatient 3	DOA Oth	er: 4 🗆 Nursing Ho	ome 5 🗆 Residen	ce 6 □Other (S)	pecify)
ū	ding Ph h. After th funeral	:uc	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of (Monti		Time of Injury	28c. Injun Worl	at	28d. Describe how		
.0	Attending in death. ector: After by the funer	ati	2 Accident investigation	1		М		Yes 2 □ No			
Division	or Atten after deat Director: in by the	tifle	3 Suicide 6 Could not be determined	286. Place	of Injury - At home, fang, etc. (Specify)	ırm, street, fa	actory, office		28f. Location (Stre	et and Number or	Rural Route Number,
	s after	Certification:	. I i i i i i i i i i i i i i i i i i i	Dallali	ig, sic. (Specify)			- 1	City or Town,	State)	
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying Ph	ysicien: To the	best of my knowledge	e, death occu	irred at the tim	ne, date and place.	and due to the cau	se(s) and manner	as stated.
	B HG B Fu	edical	(Check only 2 Medicel Exam	niner: On the ba	isis of examination an	d/or investig	ation, in my of	pinion, death occur	red at the time, dat	e and place, and d	ue to the cause(s)
	roth roth omp	Me	29b. Signature and title of certifier	/			29c. License	number	290	I. Date signed (Mo	nth, Day, Year)
	->-0		1 1/1/				0			/	** *
•				J Pe	di-trizia		100	0 444	12 1/	18/05	
1	12 1		30. Name and defines of person who	completed cause	of death (Item 23a)	(Type, Print)				_	
1			11/2 mp/x	lanes	dintrite a of death (Item 23a) Let strar's Signature	201	Eust	char	lav ort.	La Ay	5, mo
	Sta	100	31 Date lited (Month, Day, Year)	32. Re	strar's Signature	do	well				
	Registr	ar	JUL 2 1	7002	WINDLAND JO	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month GUY DAVID NOTTINGHAM 12:45P^M JULY 2005 4b, City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) CARROLL WESTMINSTER 1241 OLD TANEYTOWN RD If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Days Hours Months 10XM 2□ F 78 220-18-2918 3/15/1927 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No WESTMINSTER CARROLL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21158 TANEYTOWN RD1241 OLD 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) MYes 2 No Yes, Give KOREAN 1 ☐ Never Married 2 X Married 1 ☐ Yes 2X No Specify: Specify: WHITE Year or Dates CONFLICT 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) PROFESSOR EDUCATION 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)

Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

Funeral

Director

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

burial-tran has been signed by tt e 2 should be detachι page Con Be 0 Certification:

certificate

" - O				
	25. Was case referred to medical		26. Place of De	ath (Check only one)
nysicia nis cer direct	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpa	tient 3 DOA Other: 4 Nursing F	Home 5 N Residence 6 ☐ Other (Specify)
ath. r: After th e funeral	27. Manner of Death 1 ■ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injur		28d. Describe how injury occurred
s after dez al Directo ed in by th	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street and Number or Rural Route Numb City or Town, State)
n 24 hour ha Funara bletely fills edical (e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)
ithir ithir Me	29b. Signature and title of certified		29c. License number	29d. Date signed (Month, Day, Year)
WIL	* thunk	uli MD	035398	7-18-05
ALITA	30. Name and address of person who of	completed cause of death (Item 23a) (Type 555 Society)	wth Center St	t. Westminstor MD
01-1-	31 Date filed (Month, Day Year)	32 Re strar's Signature		

1 9

2005

32. Redistrar's Signature

		1 1	Usual Hesidence	r Decedent									
rland	ow #		10a. State	10b. County		10c. City, Town	or Loca	tion					side City Limit
Man	r 28a-f show	tor	MD.	CARROI	L	WESTM	INS	ΓER	4			1	□Yes 2XN
h the	or 28s	Director	10e. Street and Nu	mber				10f. Zip Code		10g	. Citizen of	What Country?	
death with the Maryland	23a o		1241 0	LD TANE	TOWN RD.			2115	8		USA		
er dea	Itams	Funeral	11. Marital Status	ried 2 🕅 Married	12. Was Decedent I Armed Forces?	Ever in U.S.	13. Wa	is Decedent of F es, specify Cubi	lispanic Origin? (Speci an, Mexican, Puerto Ri	fy Yes or No- can, etc.)		ce - American In ack, White, etc.	dian,
5-0030	"natural", or Itams 23a or	þ	3 Widowed		1 XYes 2 N If Yes, Give] Year or Dates:	KOREAN ONFLIC	10 T	Yes 2X No	Specify:		Speci	y: WHITE	
6 8	natu	Completed		15. Decedent's E cify only highest gr	ducation ade completed)	16a.	Deceder	nt's Usual Occup nd of work done NOT use retire	ation during most of working d)	16	6b. Kind of E	Business/Industr	′
within 1	r than	omo	Elementary/Sec 1 2		College (1-4or 5	i+)		PROFES			EDUCA	MOITA	
D E		a)	17. Father's Name	(First, Middle, Last)				18. Mother's Name (First, Middle, Ma	iden Suma	me)	
	a d a	To B		GU	Y D. NOT	TINGHAN	N		STELLA	H.	ILEMA	AN	
Maryia d 2 should	1 40 75 60	-		lame/Relationship	•				and Number or Rural				
	fealt m 2 her		20a. Method of Dis	OTTINGHA	.M - WI	The second second						- City or Town, S	
Mor	0		1 🗆 Burial 2	,	Removal from State	cemeter	y, crema JNTY	ion (Name of tory or other place) CREMA	TION 7/1				
Baitimore,	Department Important: Il any injury o		21. Signature of F	uneral Service Lic	A Live	1			ss of Facility FLE				
	nysician /Medical		23a. Part1. Enter shock, or he Immediate Cause disease or conditi resulting in death	(Final on	oplications that caused one cause di each l a Due to (or as	the death. Do n	not enter					App	roximate roal Between et and Death
	xaminer	Sequentially list conditions b.											
J, evecuted	ial-transi	Exami	Cause (Disease of that initiated even resulting in death)	ts	c. Due to (or as	a consequence	of):						
38 / b(physicia s the bur	dical			_ d.								
O. Box 68760,	inat the beatting the executed of the the transit detached for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decede in the past 1: 1 Yes 2 9 Unknow	2 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		ctopic pregnanc Other (s <i>pecify</i>)	у		T	ate of delivery lonth Day	Year
ecords, P.O	signed by	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to							ntribute to the ca			
ecor	as been si	pleted								24a. Was an autopsy	24b	. Were autopsy f	indings availab

1 Yes

2 3 NO

MD 21157

1 Tes

2 F 146

DHMH 17 Rev 1/2001

Registrar

		,	For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of H		ental Hygier	711115	253	76				
			Decedent's Name (First, Middle, I	Last)				2. Date of Death		3. Time of					
	Physici		Raymond Leonard	Nas1und				July 14	2005 Year	5:55	P M				
	/Medic Examin		4a. Facility Name (If not institution, g			4b. City, Town, or	Location of Death		c. County of Deatl		_				
			Manor Care			Chevy Ch	nase	N	iontgomer	У					
	Funeral			Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birth	place (State or	r Foreign				
	Director		380-16-0618	IES M ZUF	82 Yrs.			lay 26, 19		higan					
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside Cit	v Limits				
	/anyl	ō	MT) Mantage		Chevy Cha					1 🗆 Yes	•				
	28a-	rect	MD Montgom 10e. Street and Number	ery		10f. Zip Code		10g. (Citizen of What Co	intry?					
	with	Funeral Director	8700 Jones Brid	ge Road		20815	;	USA		,					
	ns 2:	era	11. Marital Status	12. Was Decedent E	ver in U.S. 13.		spanic Origin? (Spen n, Mexican, Puerto F		14. Race - Amer	ican Indian,					
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If term 27 is marked other than "natural", or Items 23a or 28a-f show minportant: If term 27 is marked other than "natural", or Items 23a or 28a-f show any injury or entire traumatic avent, I'm Medical Exami an must be indifficated once.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates:	942-44	lf Yes, specify Cuba 1 ☐ Yes 2 <mark>;</mark> No	n, Mexican, Puerto F Specify:	Rican, etc.)	Black, White Specify: Wh						
ŏ	ature	Completed	15. Decedent's		16a. Dece	dent's Usual Occupa	ation	16b.	Kind of Business/I	ndustry					
212	hin 7	pie	(Specify only highest (Elementary/Secondary (0-12)	grade completed) College (1-4or 5-	life.	NOT use retired	furing most of workin	g							
7	d wit giene er th	OT	,	5+		ountant		Ac	counting						
ם	al Hy i oth	Be (17. Father's Name (First, Middle, La	st)			18. Mother's Name	(First, Middle, Maide	en Sumame)						
Va Va	Ment Ment arked	2	Axel Naslund				Alma Eri								
Maryland 21215-0036	nd 2 sho alth and 27 is m r traum		19a. Informant's Name/Relationship Shellie Wood /				and Number or Rural reet NW W								
altimore,	ttem item		20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other place			Location - City or 1	own, State					
Ĕ	Page nent of				1		July	^{27,2005} Ale	xandria,	Virgin	ia				
att	Departmen Departmen mportant: any injury		21. Signature of Furneral Service Lic	ensee			is of FacilityJose	ph Gawler	's Sons						
<u> </u>	997		W little n	luna					gton, DC	20016					
I,															
	Physician	i	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons 5130 Wisconsin Ave. NW Washington, DC 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Aspiration Pneumonia												
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):										
į,		Sequentially list conditions b. Chronic Obstructive Fulmonary Disease													
	ted	Examiner	cause. Enter Underlying Cause (Disease or injury												
	al-tra	xar	that initiated events resulting in death) Last	c. Dementia Due to (or as a	a consequence of):										
8760,	ficate be executed physicien and is the burial-transit	dicai E		d Osteoari	hritis										
9	tificat ig phy as th	ledi													
Вох	eath certific attending p for use as	M/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		Ectopic pregnancy			23d. Date of deliv	-					
о. Ш	The law requires that the death certificate has been signed by the attending loage 2 should be detached for use as	Physician/Me	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	4☐Pregnant at t		Other (specify)			Month	Day Y	ear				
<u>.</u>	that the de led by the a detached f	Phy	9 Unknown				- B - 1	CO- Didash		N					
	res tha signed be del	by	Part II. Other significant conditions	s contributing to death bu	t not resulting in the u	nderlying cause give	en in Part I.		use contribute to						
Orc	w requir been si should	eted						1 162	20140 30110	Dably 42520	IKIIOWII				
Records,	a law has b e 2 si	Completed						24a. Was an autopsy	prior to co	opsy findings a ompletion of ca	vailable use of				
								performed?		2 🗆 No					
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Death								
ō	Phys this ral dii	<u>٩</u>	1 Yes 2 No 27. Manner of Death	1 Inpatier		IL 3 L OOK	4AL Nursing Hon	ne 5 Residence 8d. Describe how in		fy)	_				
O	ding I h. After funer	tion	1 ☑Natural 5 ☐ Pending	(Month, Day	Year) Injury	Work	r?` res 2 □ No	ou. 2000.100 110 11 11	ary coodinod						
Division	or Attending after death. Director: Afte in by the fune	fica	3 Suicide 6 Could not	be an Place of Injur	ry - At home, farm, sti			8f. Location (Street	and Number or Rui	a <i>l R</i> oute Numb	per,				
Ö	in Diffe	Certification:	4 Homicide	building, etc	. (Specify)			City or Town, Sta	ite)						
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical (29a. Certifier 1 Certifying (Check only one)	Physician: To the best o aminer: On the basis of and manner stat	examination and/or in	h occurred at the tim vestigation, in my op	e, date and place, a pinion, death occurre	nd due to the cause d at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)					
	o ths	Mec	29b. Signature and title of certifier	and mainter state		29c. License	number	29d. D	ate signed (Month	Day, Year)					
•	10		> kuti	Votra	M.D	D-2	0274	Ju13	y 14 , 200	5					
	1,		30. Name and address of person which the Name and address of person which the Name and Address of the Name and Address of the Name and Address of the Name and Address of the Name and Address of the Name and Address of the Name and Address of the Name and Address of the Name and Address of the Name and Address of the Name and Address of the Name and Address of the Name and Name			Print)			, , ,						
	Sta		31. Date filed (Month, Day, Year)				2001/								
	Registr		JUL 19	2005 January	r's Signatult										

			For State Registrar	State of Mary			of Health a			ene . 2.0 0 5	aca	77	
			Decedent's Name (First, Middle, Last,)		imouto	0, 200	2. [Date of Death		3. Time	of Death	
	Physici /Medic		Donna Jean O'Roa	rk					$_{ m 1y}^{ m Month}$	Day Ye. 2005	1:55	РМ	
	Examin		4a. Facility Name (If not institution, give			4b. City, To	wn, or Location of			4c. County of D	eath		
			809 London Ct			Frede		****		Frederi			
г	Funeral Director		5. Social Security Number 6. Sec. 1214-62-4503	7. Age (In	yrs. last birthday) Yrs.	If Under 1 Y Months D	Year If Under Days Hours	Min. (OC	Date of Birth Month, Day, t. 15,	^{Year)} 9.	Birthplace <i>(State Country)</i> aryland	or Foreign	
	D		Usual Residence of Decedent						. 15,	1,52 11			
	arylar show	7	10a. State 10b. County		c. City, Town or Lo	ocation					10d. Inside (City Limits s 2 ☐ No	
	the M	ecto	Maryland Frederic 10e. Street and Number	K F	rederick	10f. Zip Co	vde .		10	g. Citizen of What			
	3a or	i Di	809 London Ct			2170				nited St	•		
	death	Funeral Directo	11. Marital Status	12. Was Decedent Ever Armed Forces?		Was Deceden	t of Hispanic Ori Cuban, Mexican	igin? (Specify	Yes or No-	14. Race - A	merican Indian,		
36	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "naturel" or Items 23a or 28a-f show of other then "naturel" or Items 23a or 28a-f show event, I'n Medical Exatin actinual be notified at		1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 ☐			11, 610.7	Specify:	/hite, etc. White		
Ö	hours turel',	ed by	3 Widowed 4 Divorced 15. Decedent's Edu	Year or Dates:	16a Dece	dent's Usual C	Occupation		1	6b. Kind of Busine			
15	nin 72 n "na n Pedic	Completed	(Specify only highest grad		(Give	kind of work of DO NOT use r	done during mos retired)	at of working	'	OU. KING OF BUSINE	is s/industry		
212	d within giene.	mo	Elementary/Secondary (0-12)	4	Home 1	Maker				Own Hom	е		
nd	be filed ital Hygi id other event, I	Be (17. Father's Name (First, Middle, Last)				18. Mothe	er's Name (Fir	rst, Middle, M	aiden Sumame)			
yla	should be nd Mental marked ametic ev	10	John McGettigan				Agne						
Maryland 21215-0036	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationship (Ty Ernest O'Roark/Hu			_				City or Town, Stat Land 2170			
_	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked eny injury or other traumetic engos.		20a. Method of Disposition		Ob. Place of Dispo	sition (Name	of !	Date		Oc. Location - City			
Baltimore,	Pages ent of nt: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ F ' 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, cres St.Patric	-		7/21/0	5 C1	umberlan	1 Marul	and	
alti	permit. Departm Importal eny inju		21. Signature of Funeral Service Licens							neral Ho	ne, P.A.	and	
8	8 8 5 8		Brodley & X	my						rick,Mar		702	
	Physician /Medical Examiner	ler	23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart private. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of): Due to (or as a consequence of):										
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):								
.O. Box 6	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal déath 3	⊒Ectopic pregr] Other <i>(specii</i>				23d. Date of Month	delivery Day	Year	
rds, P	w requires that the been signed by th should be detache	by	Part II. Other significant conditions con	ntributing to death but no	t resulting in the u	nderlying caus	se given in Part I.		23e. Did toba 1 ☐ Yes	cco use contribute 2 No 3 □	e to the cause of		
I Records,	The law ate has b page 2 s	Completed							24a. Was an autopsy performe	prior		s available cause of	
Vital	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:				of Death (Ch	eck only one)			
of	Phys this ral dii	To	1 Yes 2 No	1 [] Inpatient	2 ER/Outpatier					ce 6 Other (S	pecify)		
on	fe ine	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	ar) Injury	м 250.	Injury at Work? 1 Yes 2 1		2000,100 1101	injuly occurred			
Division	Attendi ar death. ector: A by the fi	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S)	At home, farm, str	eet, factory, of	ffice		Location (Stre	et and Number or	Rural Route Nur	n <i>ber</i> ,	
	ital or rs afte el Dir led in	Cert											
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical	29a. Certifier 1 ★ Certifying Phy 2 ★ Medical Exami one)	sician: To the best of my ner: On the basis of exa and manner stated.	knowledge, death mination and/or in-	vestigation, in	my opinion, deal	d place, and o th occurred at	due to the cau t the time, dat	ise(s) and manner e and place, and c	as stated. due to the cause((s)	
ı	With To 1	Σ	29b. Signature and title of certifier	Lh.a.			icense number			d. Date signed (Mo			
•	0		sharly?	ruytman	~ M()		15368	3		111910	5		
	8		STVANCA GROW	ompleted cause of death	(Item 23a) (Type,	NS Ho	princ t	tos Pith	te	7/19/0 BAZGME	RE,	10	
	Sta Registr		31. Date filed (Month, Day, Year) JUL 2 1 2	32. Paistrar's S	aignature	Gard							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** Frances H. Olsen July 16, 10:30P 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Atria Assisted Living Salisbury Wicomico If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) Oct. 3,1904 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F 100 Yrs. Germány Director 217-42-7298 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23e or 28e-f show the Medical Ergentiner rust be notified at 1 Yes 2 □ No Director MD Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1110 Healthway Dr. 21801 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If itam 27 Is marked other than "naturat, or thans 23e any injury or other traumatic event, the Medical Examinet matt. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛛 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Ď 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Franz Hoffler Marie Kapfer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) B. Randall Coates 103 N. Church St., Snow Hill, Md. 21863 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) First Baptist Ch.Cem. 7-21-05 Pocomoke City, Md. 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William St., Berlin, Md. 21811 22a. Part1. Enter the bisease, or complications that caused the hodth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chudovasaleur diseace Physician ALLIEVOSCHIVOTI /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initíated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 2**X** No 1 ☐ Yes after death.

Diractor: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence XXOther (Specify Fa Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 1 Yes 2X No 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; Injury 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours a To the Funerel 6 29a. Certifier t 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D32014 vouile MU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Moordog 106 Willoud St Soy Is salis Bury all 218 dy MAMOSH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 2 0 2005 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Parker Terry Gibson /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 437 Ascension Street Cumberland Allegany 5. Social Security Number If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Jan 29, Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Director 234-48-3044 74 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits itam 27 is marked other than "natural", or items 23e or 28e-f show other traumatic avant, the MacLeal Examiner must be notified at MD Allegany Cumberland Completed by Funeral Director 1 Tyes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 437 Ascension Street 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 driver truck 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ould be Mental permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic av 9008. John G. Parker Esther V. McDonald Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott Parker 11215 DeHaven Rd, NE Cumberland MD 21502 son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Scarpelli Funeral Home, PA 7/27/2005 * 4 ☐ Donation 5 ☐ Other (Specify) Cresaptown MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if heart failure. List only one cause on each line. Approximate Interval Between Onset and Death EXACERBATION OF CHRUNIC OBSTRUCTIVE Immediate Cause (Final disease or condition resulting in death) Physician 4 hours /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 🗆 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 2. No 1 ☐ Yes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No Certification: To 1 🔲 Inpatient 4 Nursing Home 5 esidence 6 Other (Specify) 2 ER/Outpatient 3FT DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Magher of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 130923 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RD- NE CUMBERLANDMOZISOZ ONA 31. Date filed (Month State 0 3 2005 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

)			1 - For State Registrar	State of M	1aryland	d / Depa <i>Cer</i>	artment <i>tificate</i>	of He	ealth a Death	and M	ental H	ygiei Reg.	ne_20(05	25	380
	Physic	an	Decedent's Name (First, Middle), Last)	-						2. Date of Month	Death		Year	3. Time	of Death
Ų.	/Medi	cal	JASON TODD								July :		2005		002	2 A M
1	Examir		4a. Facility Name (If not institution				4b. City, T	own, or	Location o	f Death			4c. County o Charle			
	Funeral		Route 229 North 5. Social Security Number		Drive age (In yrs. Ia		Ponfe If Under 1	ert Year	If Under 2	24 Hrs.	8. Date of 8		CHarte		laco (Ctata	as Carrier
	Director		213-06-9949	1 TYM 2 T F	22	Yrs.	Months	Days	Hours	Min.	(Month,) MAR •	Day, Ye.		Cour	GINIA	or Foreign ∆
	put .		Usual Residence of Decedent 10a. State 10b. County		10- 01-	, Town or Lo										
	Aarylan f ahow	ö												1	0d. Inside (City Limits s 2 ☑ No
	the 28a-	Director	MARYLAND CHA 10e. Street and Number	RLES	N	VALDO	10f. Zip (^ode				100	Citizen of W	hat Caus		
	h with		1105 CLINTON	COURT				602				log.	U.S.		uy?	
	eme	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S		Vas Decede	ent of His	panic Orig	gin? (Spec	cify Yes or I	No-	14. Race	- Americ	an Indian,	
36	s afte	by Fu	1 Never Married 2 Marri	ed 1 ☐ Yes 2X If Yes, Give	X 0		Yes, specif		Specify:	, rueito r	ncari, etc.)		Specify:	, White,	atc.	
9	72 hours after death with the Maryland natural', or Iteme 23s or 28e-f show dical Examiner must be notified at	ed b	3 Widowed 4 Divorced	Year or Dates:	:							1			ITE	
21215-0036	within 72 ene. than "ne	plet	(Specify only highes	t grade completed)	.5.)	(Give	kind of work	done du	ırina most	of workin	g	160.	Kind of Bus	iness/inc	Justry	
21	giene.	Com	12	1 1	5+)	ASSIS	тиатг	ч м д	NAGE	ī.R			LEDO	I C I	OT <i>771</i>	^
pul	be filed within 72 hours after death with the Maryla ital Hygiene. id other than "natural", or Iteme 23s or 28s-f ahov avent, the Madical Examinar inual se rodified at	Be (17. Father's Name (First, Middle, I	.ast)							(First, Midd	le, Maid			-122	1
y la	should by hd Menta markad imatic av	2			AK											
Maryland	d 2 sho th and 1 7 is ma traums				шпр											
	s 1 and 2 should f Health and Mer ltem 27 is marks other traumatic		20a. Method of Disposition	NAK - MOT	20b. Pla	ace of Dispos	sition (Name	e of	1							02183
E G	9 ° = =				9				1					•		
Baltimore,	permit. Pag Department Important: I any injury o			HEIR							-05	AI	<u> EXAN</u>	DRI	4, VE	4
m	90 E 5 8		Michal													
			17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame JOSEPH RONALD PASTERNAK 19a. Informant's Name/Relationship (Type, Print) SUSAN PASTERNAK — MOTHER 25768 GRIST MILL DR., MARDELA SP 20a. Method of Disposition 1 Burial 22 K remation 3 Removal from State 4 Donation 5 Other (Specify) METROPOLITIAN CREMATORY 7-30-05 ALEXAN 21. Signature of Funeral Service Licensee MO0479 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fany, leading to immediate Burial 22 K remation 3 Removal from State A Donation 5 Other (Specify) METROPOLITIAN CREMATORY 7-30-05 ALEXAN 25. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A 25. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A 25. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):													ate etween
1	Physician /Medical		disease or condition	a	MUL	-TIPI	E	I.	してい	RIR	(2)				Onset and	I Death
	Examiner		and and and and and and and and and and	Due to (or as	s a conseque	ence of):		•								
		er	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	s a conseque	ence of):								-		
V	cuted nd ransit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events													
0,	be executed sicien and burial-transit		resulting in death) Last	Due to (or as	s a conseque	ence of):										
8760,	the the	dicai		d												
9 X	eath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, outcome	e of pregnan	101										
Вох	death certifi e attending I id for use as	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth	2 Fetal o	death 3 🔲	Ectopic pred Other (spec	gnancy					23d. Date Mont		_	Year
O.	the che	hys	9 Unknown	9□ Unknown			(0,000									
S, D	es thet igned b	by P	Part II. Other significant condition	ns contributing to death I	but not result	ting in the un	derlying cau	ise given	in Part I.		23e. Did	tobacco	use contrib	oute to the	e cause of	death?
Vital Records,	The law requires tte has been sign page 2 should be	ted									1] Yes	2 000 3	Proba	ably 4 🗌	Unknown
Sec.	e law has b	Completed									24a. Wa	s an	24b. We	ere autop	sy findings	available
a											1 Yes	formed?	de	ath?	2 🗆 No	
Ξ	Physician: This certifical	o Be	25. Was case referred to medical examiner? 1 ★ Yes 2 □ No	Hospital:		70.0		Other			Check only		/			
	g Phys er this eral di	n: To	27. Manner of Death	28a. Date of Inju		R/Outpatient 28b. Time of		. Injury a Work?	4 🗀 19013				6200ther			scene
Division	Attending r death. sctor: After y the fune	ertification:	1 Natural 5 Pending 2 Accident investig	ation 7/24/	or rear)	0012	м	Work? 1 ☐ Ye		1	- CAR	wh	OBJE	STR	VLK.	4
Ξ	or Att	rtific	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	ned 286. Place of in	jury - At hom	ne, farm, stre	et, factory,	office		28	If. Location	(Street a	and Number	or Rural	Route Nun	nber.
	Hospital or 24 hours afte Funeral Dir tely filled in	0				LUM				1.0	r(Am	CLUI	DEINA	E PU	MERA	T. 20
	To the Hospital or Attending Phymin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 Certifying Medical B	Physician: To the best examiner: On the basis of and manner st	or examinatio	rledge, death on and/or inve	occurred at estigation, in	the time my opir	, date and nion, death	place, an	d due to the	e cause(, date a	s) and manr nd place, an	ner as sta d due to	ited. the cause(s	s)
	To the To the To the Complet	Me	29b. Signature and title of certifier	- did mainer si	ialeu.		29c. t	License r	number			29d. D	ate signed (Month. E	Dav. Year)	
			· · · /	// / ~				OCI	Œ				y 24,			
-	1		30. Name and address of person v	who completed cause of	death (Item 2	23a) (Type, F	Print)		~							
	2		MAN 31 Days filed 11 11 11 11 11 11	y G. RIPP	LENV)	111	Per	ın Stı	reet	Balt	imo	re, Ma	ryla	nd 21	.201
*	Sta Registr		31. Date filed (Month Dag Greg)	3 2005 32. Régisti	rar's Signatu	or A	and !									

			State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. NO 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
	Physic		1. Decedent's Name (First, Middle, Last) ROSA LEE FORD PROCTOR 2. Date of Death 3. Time-of Death 3.55 A	М
	/Medi Exami		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FORT WASHINGTON HOSPITAL FORT WASHINGTON PRINCE GEORGES	
	Funeral Director		5. Social Security Number 214-42-4551 6. Sex Yrs. 63 Yrs. 63 Yrs. 63 Yrs. 63 Yrs. 63 Yrs. 63 Yrs. 63 Yrs. 63 Yrs. 8. Date of Birth (Month, Day, Year) JUNE 14,1942 9. Birthplace (State or Fore Country) WARYLAND	∍ign
	death with the Maryland ms 23a or 28a-f show I must be notified at	Irector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lim MARYLAND CHARLES BRYANS ROAD 1 □ Yes 2√√ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
215-0036	72 hours after "neturel", or Ite	Completed by Funeral Director	2301 WOODBERRY DRIVE 20616 UNITED STATES 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Thio If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 Thio If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 Thio If Yes, specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry	
2	should be filed within and Mental Hygiene. marked other than "matic event, the Men	Be	PRIVATE 17. Father's Name (First, Middle, Last) LEO FORD College (1-4or 5+) HOUSEWIFE PRIVATE 18. Mother's Name (First, Middle, Maiden Sumame) VIOLA JOHNSON	_
Baltimore, Maryland	ages 1 and 2 should ent of Health and Me nt: If item 27 Is mark y or other traumation	To	19a. Informant's Name/Relationship (Type, Print) JAMES A. PROCTOR, JR./ HUSBAND 2301 WOODBERRY DRIVE, BRYANS ROAD, MARYLAND 20616 20a. Method of Disposition 1 \(\begin{align*} \text{ Location - City or Town, State, Zip Code} \) 20b. Place of Disposition (Name of cometery, crematory or other place) 1 \(\begin{align*} \text{ Location - City or Town, State, Zip Code} \) 20c. Location - City or Town, State 20	<u>,</u>
Baltir	permit. Pages Department of Important: If if any injury or once.		21. Sin ture of Funcial Seek, the new THORNTON FUNERAL HOME, P.A. 121. Sin ture of Funcial Seek, the new THORNTON FUNERAL HOME, P.A. 122. Sin ture of Funcial Seek, the new THORNTON FUNERAL HOME, P.A. 123. Sin ture of Funcial Seek, the new THORNTON MOODS 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20)64
68760,	physician and physician and physician and physician and physician and step purial-transit	edical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Schock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	b
O. Box	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 27 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery 23d. Date of delivery Month Day Year Year	
Δ.	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 2 2 2 2 2 2 2 2	₩n
Vital Records,	Physicien: The law re this certificate has bee ral director, page 2 sho	Be Completed	24a. Was an autopsy performed? 25. Was case referred to medical examiner? Hospital: Other:	ole if
Division of	ttending Physical distribution of the funeral distribution	Certification; To	27. Manner of Death 1 Shatural 5 Pending investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Bural Route Number.) 28d. Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred	
Οį	To the Hospital or A within 24 hours after To the Funerel Directompletely filled in by	Medical Cert	29a. Certifier (Check only one) 29a. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
)	To the within To the comple	Me	29b. Signature and title of certifier A. M. Alelelan W 29c. License number 7-18-2005	
SI	764		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMIR MIRZA-ALIKHANI, M.D. 11711 LIVINGSTON ROAD, FORT WASHINGTON, MARYLAND 20745	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Refistrar's Signature 32. Refistrar's Signature	

	,		For State Registrar	State	of Maryla	•	artment rtificate				lental H	lygier Reg. N		O 1000	0 = 0	
			1. Decedent's Name (First, Middle, Las	it)							2. Date of Month	Death	Day	Year	a Time of De	Atl-
	Physici /Medio		Ronald Lee PRYOR								July	19	200		6:30	рМ
Ė	Examin	-4	4a. Fecility Name (If not institution, give	street and n	ımber)		4b. City, 1	Town, or	Location	of Death		4	4c. County	of Death		
			16865 Shinham Ro	ad				Hage	ersto	wn			Was	shing	ton	
	Funeral		Social Security Number 6. S		7. Age (In yrs	s. last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of (Month.	Birth Day, Yea	ar)	9. Birth Cou	place (State or F	oreign
	Director		212-38-92/0	M 2□F	64	Yrs.					Aug.			Ma	ryland	
	pu *	-	Usual Residence of Decedent 10a. State 10b. County		100.0	City, Town or Lo	cation								10d. Inside City I	imito
	arylan ehow	5			100.0	Ny, TOWN OF E	Callon								1 ☐ Yes 2]	
	Ba-f	Director	Maryland Washing	ton		Hage	rstow									2
	with t	급	10e. Street and Number				10f. Zip					10g. (Citizen of V		ntry?	
	I within 72 hours after death with the Maryland liene. r then "natural", or Items 23e or 28e-f ehow tre Medical Exans ret mast be reditied at	ra	16865 Shinham Ro		3 1 3 1 2 1 3 1			217					US			
	er de Item	Funeral	11. Marital Status	Armed F		0.5. 13.	If Yes, spec	ent of Hi ify Cuba	n, Mexicar	n, Puerto	ecify Yes or Rican, etc.)	No-		e - Amen :k, White,	can Indian, etc.	
5	hours after tural, or Ite	by F	1 Never Married 20 Marned 3 Widowed 4 Divorced	If Yes, G Year or	2 X No ive		1 🗆 Yes 2	X) No	Specify:				Specify	C T.Tle 4	***	
2-0030	hour ture	edit	15. Decedent's Ed		24(63.	16a Dece	dent's Usual	l Occups	ation			16h	Kind of Bu	Whi		
Ċ	within 72 ene. then "ne!	Completed	(Specify only highest gra	de completed		(Give	kind of wor	k done d	during mos	t of work	ing	100.	Kind of Bo	13111033/11	loustry	
7	with ene.	E	Elementary/Secondary (0-12)	Callege	(1-4 <i>a</i> r 5+)	carr	enter		,			CO	nstru	otic	m	
0	Hygent,		17. Father's Name (First, Middle, Last)		· · · · · · · · · · · · · · · · · · ·	Carp	CHUCI	T	18. Mothe	er's Name	e (First, Midd				, LI	
ysand	D 6 5 U	To Be	Charles Jacob Pr	wor.					Ца	g o 1	Helen	Room	·d			
_	2 shoul and M is mar! eumati	-	19a. Informant's Name/Relationship			19b. Maili	na Address	(Street a			al Route Nur			State. Zii	Code)	
E S	d Z		Shirley E. Pryor	_ vrif.							Hagers					
ē,	a d E d	1	20a. Method of Disposition	_ WII.		Place of Dispo	sition (Nam	e of			Date		Location -			
ᅙ	eges intof t: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐			cemetery, cre				7/22	/OF	11-			M = 1	
Barrimore	artme artme orten injury		*4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		Ke	st Have	2. Name and			7/23	innich				Marylar	ıα
n	permit. Peges. Department of Himportent: If its eny injury or of		RA ACI	0.							. Hag					
F			23a. Part1. Enter the disease, or com	olications that	caused the dea								,	114.	Approximate	
			shock, or heart failure. List only Immediate Cause (Final	one cause on	each line.										Onset and Dea	en ith
i,	Physician /Medical		disease or condition resulting in death)	a	A w 1	e M	youar	9101	7	-nto	chion					
	Examiner			Due to	(or as a conse	equence of):	0									
		<u>-</u>	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conse	equence of):										
	ted	ij	cause. Enter Underlying Cause (Disease or injury		,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,										
	xecu a and al-tra	Examiner	that initiated events resulting in death) Last	C. Due to	(or as a conse	equence of):								+		
3/60	be e	dicai E														
9	phys phys s the	ggi		d												
×	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome of pregr	nancy							23d Dat	te of deliv	90/	
ROX	atter	ciar	in the past 12 months?		birth 2 Fe		Ectopic pre Other (spe						Mo		Day Yea	r
j	by the a	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unk			2 0 11.0. (0,00	,,				-				
7	requires that the een signed by th hould be detache		Part II. Other significant conditions c	ontributing to	death but not re	sulting in the u	nderlying ca	use give	en in Part I		23e. Di	d tobacc	o use cont	ribute to 1	he cause of deal	h?
ds,	uires I sigr Id be	d by	Recei	+ G	، اطاله	dlen	Sur	400	4		11	Y es	2 🗆 No	3 Pro	oably 4 Unk	nown
Vital Record	> 3	Completed						3	1		24a. W		24b 1	Aloso out	ney findings ave	ulabla
ě		ш								-	au	topsy rformed?	, r		opsy findings ava impletion of caus	
_ 											1 ☐ Yes	2			2 No	
=	ricier certif recto	Be	25. Was case referred to medical examiner?	Hospital:				Othe			h (Check on					
ō	Phys this rat di	<u>1</u>	1 Yes 2 No 27. Manner of Death	28a. Date		ER/Outpatie			4 L N	irsing Ho	me 5 R		6 Oth		<i>(y)</i>	
	ding F h. After funer	ion	Natural 5 Pending	(Mo	nth, Day Yeer)	Injury	M	Bc. Injury Work	Yes 2 🗍		200. Descrit	HOW IN	ijury occuri	ea		
<u>s</u>	offending death.	cat	2 Accident investigation 3 Suicide 6 Could not be		o of lower At	home larm at			163 2 🗆	NO	201 Legation	/Ctront	and Mumb	as as Our	of Clause Alverta	
DIVISION	of or Attence after death I Director:	Certification:	4 Homicide determined	build	e of Injury - At ding, etc. (Spec	cify)	reet, ractory,	, office				Town, Sta		er ar Hur	al Route Number	
_	pitel ours a erel		29a. Certifier 1 Certifying Ph	veicien: To th	a bast of my kr	nowledge does							() !	200		
	Hos 24 hc Fun stely	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	mger: On the	basis of examir	nation and/or in	vestigation,	in my of	oinion, dea	ith occur	red at the tim	e, date a	and place,	and due t	tated. o the cause(s)	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Me	29b. Signature and title of certifier				29c.	License	number			29d. f	Date signed	d (Month	Day, Year)	
,			11060													
	33		20 Normand address of the Control of	- ws		00-1 7			764				7/234	105		
	7	Ì			use of death (Ite		A	-6.1	. 01	C	t 12	7 1	4	1	F15 am	71
	Sta	to.	31. Date filed (MoMin Day, Year)		Registrar's Sign	me 2 c	V	p.	2) 10 4)		. !	1= 5.8-1	1844	WID C(4	100
	Registi		JUL 25 20	05	aggistrar's Sign	A. A.	and I									
DI	HMH 17 Bev 1/2		30L N 0 2(100	WELLOW !	w. Wo										

DHMH 17 Rev 1/2001

CPM 05-04608 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Charles Perkins, Jr. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 08, CHARLES ROBERT PERKINS, JR. July 2005 17:18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Reeds Creek boat landing Centreville Queen Anne's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday). Date of Birth (Month, Day, Year) 1961 9. Birthplace (State or Foreign **Funeral** Days Hours 1XM 2□ F MARYLAND Yrs 213-82-5324 44 Director Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. tnside City Limits Show the Mudical Examiner must be notified at QUEEN ANNE'S QUEENSTOWN MD Director 1X Yes 2 □ No 28a-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21658 USA 311 DEL RHODES AVENUE ітетв 23а Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 'natural' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) GROCERY STORE 12 MANAGER -0othert other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental marked o DORIS KNOX CHARLES ROBERT PERKINS, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 311 DEL RHODES AVE., QUEENSTOWN, MD 21658 CHARLOTTE PERKINS/ WIFE item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of h important: if its eny injury or of once. 1 ■ Burial 2 Cremation 3 Removal from State WOODLAWN MEMORIAL PARK 7-14-2005 EASTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 2161 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one calculate the complex control of the calculate the complex calculates a complex calculates a calculate the calculates and calculates a calculate the c aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): law requires that the death certificate be executed attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a Ö 9 Unknown 9 Unknown ۵ Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signer 2 Records, 1 🗆 Yes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has I death? Yes Vital 2 No 2 No Yes : After this certification of funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 - Nursing Home 5 - Residence 6X Other (Specify) SCENE 1X Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA o 28a. Date of Injury (Month, Pay 27. Manner of Death 28b. Time of Injury Certification: 28d. Describe how injury occurres Division 1 Natural 5 Pending death. investigation Director: / 2 Accident 5 6 Could not be 3 Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Nu City or Town, State) filled in by Rural Route Number after after hin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Communication. Support the cause of the cause 29a, Certifier and manner stated within 2

12/JuA

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

32. Rea

JUL 1 2 2005

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street Baltimore, Maryland 21201

OCME

29d. Date signed (Month, Day, Year)

July 09, 2005

5-05021 JM		1 - For State Unpend Item Registrar	State of Marylan	d / Depa	rtment of H	ealth and	Mental Hy	/giene	Legible.				
	_			er me (ificate of 9	Death cas			005	25384			
Physician	۶ 1	1. Decedent's Name (First, Middle, La	ist)				2. Date of D Month	Day		3. Time of Death			
/Medical		IOZSEF PAVAI 4a. Facility Name (If not institution, gin	re street and number)		4b. City, Town, or	Location of Deat	July	25	5 2005 County of Death				
Cxammer		Carroll Hospital		1000	Westmi				Carroll	'			
Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs. I	**	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, D	rth ay, Year)	9. Birth	place (State or Foreign intry)			
Director		930-71-9386 Usual Residence of Decedent	64	Yrs.			Oct. 29	, 194	10 Rom	ańia			
anyland show	Ì	10a. State 10b. County	10c. City	, Town or Loc	ation					10d. Inside City Limits			
vith the Mar	000	MD Prince G	George's Bre	ntwood						1 X Yes 2 □ No			
036 ours after death with the Maryla fel; or Nems 23a or 28a-f shot Exerciser must be conflicted at the Filineral Director	2	10e. Street and Number			10f. Zip Code			10g. Citiz	zen of What Cou	intry?			
fitter death virtheme 23st	2	4509 38th Place	12. Was Decedent Ever in U.	S 13 W	2072		Speedy Vee or N		mania 14. Race - Amer	inga Indian			
or Item		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	lf	as Decedent of Hi Yes, specify Cuba		to Rican, etc.)		Black, White				
OURS & COURS &	, o	3 Widowed 4 Divorced	If Yes, Give 12 Year or Dates:	1	☐ Yes 2大 No	Specify:			Specify: Wh	nite			
21215-0036 ed within 72 hours after death with the Maryland ygiene, than "naturel", or Nems 23a or 28a-f show it, the Mydical Exercitor must be exhibited at Completed by Finneral Director	בנפ	15. Decedent's E (Specify only highest gr		(Give k	ent's Usual Decupa and of work done of ONOT use retired	turing most of wa	rking	16b. Kir	nd of Business/li	ndustry			
		Elementary/Secondary (0-12)	College (1-4or 5+)		Contracto			Cor	nstructi	on			
the filed of other sevent, I		17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle						
arylane should be nd Mental marked o		Iozsef Pavai				Margit	Racz						
40 0 0 0	Ì	19a. Informant's Name/Relationship											
ma deal	ł	Adrian Petrus, Fr 20a. Method of Disposition	20b. P	lace of Dispos	ition (Name of		, Hyatts						
Pages nent of int: if it		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donayon 5 ☐ Other (Speci	Removal from State	emetery, crem	atory or other place	1	0/2005						
Baltimore, permit. Pages 1 a Department of Hes Important: If tem any Injury or othe once.	ł	21. Signature of Funeral Service Lice	PICU		n Cremator Name and Addres		8/2005 asch's E						
o 88 e 8		Jan L. ache	ller										
The state of the s		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.	. Do not ente	r the mode of dying	g, such as cardia	c or respiratory	arrest,		Approximate Interval Between			
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	aDilated Cardi		thy Compl	licated V	with Hyp	erth	ermia	Criser and Death			
Examiner			Due to (or as a consequ	ience of):									
3	0	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequ	ience of):									
60, be executed icien and burial-transit		cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C										
2 B G G	2		Due to (or as a consequ	ience or):						White of Business/Industry struction umame) Town, State, Zip Code) , Maryland 20782 tion - City or Town, State undria, Virginia 1 Home, P.A. ille, Maryland Approximate Interval Between Onset and Death Trmia Date of delivery Month Day Year contribute to the cause of death? No 3 Probably 4 Minknown 24b. Were autopsy findings available prior to completion of cause of			
	מַר	•	_ d										
P.O. Box 68 nat the death certifics do by the attending of letached for use as it Physician/Med		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna.		Ectopic pregnancy			2	3d. Date of deliv	ery			
O. B. Be death the attribed to hed for	2	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at time of de		Other (specify)				Month	Day Year			
P.O. B. that the death ed by the atte detached for		Part II. Other significant conditions	contributing to death but not resu	ulting in the uni	tertuing cause give	on in Part I	23e Did	tobacco u	se contribute to	he sause of death?			
Division of Vital Records, or attending Physician: The law requires the death. Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by	2				ony my outdoo give			Yes 2					
aw requir	מפונ						24a. Was	an	24b. Were auto	opsy findings available			
Il Record The law requir cate has been s page 2 should	5							psy ormed? 2□ No	prior to co death?	ompletion of cause of 2 No			
Vital P		25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only		123 103	2010			
of Vita Physician: this certific		1 Yes 2 No 27. Manner of Death	Ho spital: 1 ☐ Inpatient 2 🔯 I 28a. Date of Injury	ER/Outpatient		4 Nursing F	lome 5 ☐ Res			fy)			
on ding lding lth.		1 ☐ Natural 5 ☐ Pending 2 🛣 Accident investigatio	Found	Forme of	28c. Injury Work	at ? ∕es 2 □No	Subject	: Worl	king Out	side On 90			
Division C teal or Attending P rs after death. al Director: After I ed in by the funera Certification:	2	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho	me, farm, stre						emperature al Rowe Number, rfair Way			
Di rs afte eal Dir		4 Tromicide	Scene	, 			Sykesvi	un, State)	Md May	fair way			
Division To the Hospital or Attentivitin 24 hours after deatt To the Funeral Director: completely filled in by the	2	29a. Certifier (Check only one)	nysician: To the best of my know miner: On the basis of examinat	wledge, death ion and/or inve	occurred at the timestigation, in my op	e, date and place inion, death occu	and due to the	cause(s) date and	and manner as s	stated. o the cause(s)			
o ths omple	I MICH	29b. Signature and title of certifier	and manner stated.		29c. License				signed (Month,				
		> auat	`		OCM	E			y, 26,				
CR (2)		30. Name and address of person who		23a) (Type, P	rint)								
		31. Date filed (Month, Day, Year)			Street, E	Baltimor	e, Maryl	and					
State Registrar		JUL 2 9 2005	32. Registrar's Signat	Good	وج								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 2005 July 5:06 AM David Warner Phillips /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb. 28, 1953 Birthplace (State or Foreign Country)
 West Virginia Funeral Months Days Hours 1 € M 2 □ F 232-86-1763 52 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Mcdical Examiner must be notified at 1 ☐ Yes 2 X No Director Frederick Maryland Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8814 Eureka Lane 21793 United States deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes. Give Year or Dates: 1986 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer d Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Item any injury or other treumatic event, the Mcdical Exemples 2009. 1 ☐ Never Married 2 TX Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Systems Engineer Aero Space 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Cecil Warner Phillips Thelma Reese 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Phillips / Wife 8814 Eureka Lane, Walkersville, MD 21793 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Frederick Crematory 7/19/2005 `4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, I any, I am g to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 □ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? No 1 Yes Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one, ٩ 1 Yes 22 No inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Natural 5 Pending death. 2 No 2 Accident investigation Director: in 24 hour.
I the Funerel Direc. 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) within 2 To the ۽ 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) William D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William 000 milesmi 31. Date filed (Month, Day) Year) 32. Registrar's Signature 2005 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death Reg. 2005 25386	,)
	Physic		1. Decedent's Name (First, Middle, Last) Charles R. Peomroy 2. Date of Death Month July 20, 2005 3. Time of Death July 20, 2005	
	/Medi Examii		4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
	Funeral Director		St. Catherines Nursing Home Emmitsburg Frederick 5. Social Security Number 217-12-1631 6. Sex 1	eign
	hend was		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lin	nits
	e Mary	ctor	Maryland Frederick Rocky Ridge 1□Yes 2☒	No
	s with th	i Dire	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13812 Motter Station Rd. 21788 United States	
020	within 72 hours after death with the Marylend ene. than "natural", or Items 23a or 28a-f show he Medical Examina, must be notified at	Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1	
Baltimore, Maryland 21215-0020	be filed within 72 ho ntal Hygiene. of other than "natur event, the Medical	ompietec	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver 16b. Kind of Business/Industry Trucking	
yland 2	should be filed and maked Mental Hygis marked other urnatic event, I	To Be Co	17. Father's Name (First, Middle, Last) John R.K. Peomroy, Sr. 18. Mother's Name (First, Middle, Maiden Sumame) Ida Hummrick	
Mar	d2 thar 7 is		19a. Informant's Name/Relationship (Type, Print) Connie Humerick / Granddaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13812 Motter Station Rd., Rocky Ridge, MD 21788	
timore,	iges 1 it of He if Item or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Tabor Cemetery 20c. Location - City or Town, State 7/23/05 Rocky Ridge, Marylan	ıd
Bali	permit. Pa Departmen Important: any injury		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 104 East Main Street, Thurmont, MD 21788 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.	
	Physician ,,wedical Examiner	<u>.</u>	23d. Part1. Enter the disease, or complications hat/caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of)	
, 68760,	rtificate be executed ng physician and as the burial-transit	Medicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):	
ords, P.O. Box	Attanding Physician: The law requires that the death certificate be executed to death. The death certificate hes been signed by the attending physician and ector. The thin funeral director, page 2 should be detached for use as the burial-transit	ed by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 To 3 Probably 4 Unknown and the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death underlying cause given in Part I. 1 Yes 2 To 3 Probably 4 Unknown and underlying cause given in Part I. 24a. Was an autopsy performed?	own
Reco	The law re ste hes be bage 2 sho	Completed	completion of cause of death?	
Vita	ician: certifice rector, p	Be	25. Was case referred to medical examiner? 1	
Division of Vital Records,	To the Hospital or Attending Physicien: The law within 24 burus filter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To	27. Mapner of D th 27. Mapner of D th 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No	
Divis	To the Hospital or Attendi within 24 hours efter death To the Funeral Director: A completely filled in by the f	Certific	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	ne Hospil n 24 hour ne Funera sietely filli	edicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
)	To the within the complex of the com		29b. Signature and title of Certifier 29c. License number 29d. Date signed (Month, Day, Year)	
•	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
	Sta Registra	76	31. Date filed (Month, Day, Year) 32. Degistrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of M	aryland / De	partment of l e <i>rtificate of</i>		Mental H	ygiene Reg. Ne?		0000
	Dhi.		Decedent's Name (First, Middle,					2. Date of D	eath C	.005	G. Tuheud Beath
	Physici /Medic		Esteban	Sierra	Pena			JULY		2005 Year	0422 A M
	Examir	er	4a. Facility Name (If not institution, WASHINGTON ADVE			4b. City, Town, TAKOMA	or Location of Dea	ath		County of Death	RY
24.	Funeral Director	H1	922-71-1560	7. Ag 1 1 M 2 I F	ge (In yrs. last birthda 28 Yrs.	y) If Under 1 Year Months Days			irth (ay, Year) , 197	9. Birthp Cour 6 Mex	place (State or Foreign htry) LCO
П	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits
	Mary I sh	ţō	MD Prince	George	Mt. Raiı	nier					1 ☐ Yes 2 ☐ No
	th the	irec	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Cour	ntry?
	ath wi	rai	452129			20712			1	exico	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 ahow any injury or other traumatic avent, I'm Medical Examinat mat be inclined at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	Ever in U.S. 1:	3. Was Decedent of If Yes, specify Cub X 1 ☐ Yes 2 ☐ No	Specify:	Specify Yes or Norto Rican, etc.) Kican		14. Race - Americ Black, White, Specify: Whi	etc.
21215-0036	72 hou natura licul E	ted	15. Decedent's (Specify only highest	Education	16a. Dec	cedent's Usual Occu ve kind of work done	nation		16b. Kir	nd of Business/In	
21	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or	5+) life	. DO NOT use retire	auring most of w	orking			
	iled w dygier ther ti		Unk 17. Father's Name (First, Middle, L.	et)	- Ua	arpenter	10 Matheda No	ame (First, Middl		ptentry	
and	d be f antal l	э Ве	Lorenzo Sierr	•				lad Pena	ө, маюөп	Sumame)	
Maryland	shoul ind Me i mari umati	To	19a. Informant's Name/Relationshi	(Type, Print)	19b. Ma	iling Address (Stree			ber, City or	Town, State, Zip	Code)
	and 2 valth a 27 is		Gloria Mirele	s - Sister	Ro	oute 1 Box	65 E E	dcouch,	TX 78	538	,
ore	of He		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation	Removal from State	20b. Place of Dis cemetery, c	position (Name of rematory or other pla	ice)	Date	20c. Lo	cation - City or To	own, State
Ě	Pag tment tant:		4 □ Donation 5 □ Other (Spe	cify)		ador Ceme	1	-22 - 05	San	Salvador	, Mexico
Baltimore,	permit Depar Impor any in		21. Signature of Funeral Service C	books			e Highwa	y Falls	Chur	ch, VA	22046
1 A			23a. Part1. Enter the disease, or c shock, or heart failure. List or	emplications that cause by one cause on each i	d the death. Do not e	nter the mode of dyi	ng, such as cardia	ac or respiratory	arrest,		Approximate Interval Between
5	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	nshot h	round t	o ches	7			Onset and Death
45	Examiner			Due to (or as	a consequence of):					7	
		Jer	Sequentially list conditions, if any, leading to infinitediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	à consequence of).						
	tificate be executed g physician and as the burial-transit	Examiner	that initiated events	c.							
9	De exe		resulting in death) Last	Due to (or as	a consequence of):						
68760,	cate b physic the b	edicai		d						-	
			IF FEMALE:	23c. If yes, outcome	of pregnancy					Od Data of dating	diament of the state of the sta
.O. Box	The faw requires that the death cer are has been signed by the attendir bage 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	Ectopic pregnanc	y			3d. Date of delive	Day Year
ds, P	uires tha signed Id be dei	۵	Part II. Other significant condition	contributing to death b	out not resulting in the	underlying cause gr	ven in Part I.		tobacco us		ne cause of death?
S	w req	lete						24a. Wa	s an	24h Were auto	psy findings available
Division of Vital Records,	ilcian: The lav certificate has rector, page 2	Completed						auto			inpletion of cause of
Ĭ	s certi	o Be	25. Was case referred to medical examiner? XXYes 2 □ No	Hospital: 1 ☐ Inpatie	ent 2XER/Outpati	ot so so lot		eath Check only			
٥	Attending Physician: r death. ector: After this certific by the funeral director.	Ë	27. Manner of Death	28a. Date of Inju		of 28c. Inju	4 🗆 Nursing	28d. Describe		☐Other (Specify occurred	/)
<u>Ö</u>	andin ath. or: Aft	atio	1 □Natural 5 □ Pending 2 □ Accident investiga	ion 7/16/05		€ M 1□	Yes 2 No	Subje	ret -	shot	
Divis	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ury - At home, farm, s c. (Specify)	city factory, office		28f. Location City or To	(Street and wn, State)	Number of Aura 2000 BIK SVILLA	Route Number LANGERSTY
	To the Hospital or within 24 hours after To the Funeral Dir. completely filled in I	edical	29a. Certifier 1☐ Certifying (Check ore) 2∑ Medical E)	Physicien: To the best aminer: On the basis of and manner st	CRAHIMIATUR AND OF	ath occurred at the transition, in my	me, date and place	e, and due to the	Caucole)	and manner as ct	alad
)	Withi Comp	Σ	29b. Signature and title of certifier Zaluill	ish Al		29c. Licens	c.M.E		29d. Date	signed (Month, I	2005
	'		30. Name and address of person when the contract of the contra	o completed cause of d	leath (Item 23a) (Type 1111 PE	NN STREET	, BALTIM	ORE, MARY	ZLAND	21201	
	Sta Registr		31. Date filed (Month, Day, Year) JUL 19 2	39. Registr	ar's Signature	uli					

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

768			Please	Type or Prin					-		_	e.
	4	For Stata		State of Ma	aryland /		artment of H					- 05000
	1	Registrar	/Fi A B S d d d	A)		Ce	rtificate of	Death			2005	
Physician /Medical	Α	ndre	e (First, Middle, Las		trick				2. Date of De Month July	Da Da		3. Time of Death 10:48 P M
Examiner			f not institution, give er Avenue	street and number)				r Location of Death		40	County of [
Funeral	^	ocial Security N			je (In yrs. last b	irthday)	Suit1	If Under 24 Hrs.	8. Date of Bir	th		e George's
Director		7-88-1		X M 2□ F	37	Yrs.	Months Days	Hours Min.	(Month, Da 9/16/	ıy, Year,		Birthplace (State or Foreign Country) ashington, Do
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural; or items 23s or 28s-f show my injury of other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10a.	State d.	10b. County Prince	Georges	10c. City, To		cation Hills					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
uter death with the Mar r Items 23s or 28s-f el niner must be notified Funeral Director	10e. 59	Street and Nur	sher Rd.				10f. Zip Code 20748			_	tizen of Wha	t Country?
ema 2	11. 8	Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No)-		American Indian, White, etc.
ours after rral', or its Examina d by Fu	3	☐ Never Marri	ed 2 Married 4 Divorced	1 ☐ Yes 2 ☒ I If Yes, Give Year or Dates:			1 ☐ Yes 2X No	Specify:	110411, 010.7			black
ed within 72 hor ygiene. her than "natura nt, the Wedical E		(Spec	15. Decedent's Ed	ucation de completed) College (1-4or 5		(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of work	ing	16b. K	and of Busin	ess/Industry
ygiene rer the		12		College (1º401 c)**/ C	hef				US	Navy	Yard
be file	17. F		(First, Middle, Last)					18. Mother's Nam				
d Men marke matic		alter	${f P}$ ame/Relationship (T	atrick	10	h Maili	ng Address (Street	Shirley			anks	An 7:- Codel
ith an			e Patrio		7.1	623	-					Md. 20735
item	20a.	Method of Disp	position		20b. Place	of Dispo	osition (Name of matory or other place		Date	20c. L	ocation - City	or Town, State
: Page tment c tant: if		4 Donation	5 Other (Specify	/	Maria .	dal	le Park	// 1:	9/05	Riv	erdal	le, Md.
Depar Impor eny in	21.	Signature Fu	neral Service II cens	15		41	2. Name and Addres 1 Kenne	dy St.,	iversa N.W.	l M Was	ortua hingt	ary con,DC 20011
Physician /Medical Examiner	Imm	Part1. Enter the shock, or head dediate Cause (lase or condition alting in death)	Final	dications that caused one cause on each line. a	ne.	gui	er the mode of dyin		or respiratory a	rrest,		Approximate Interval Between Onset and Death
ysician and e burial-transit cal Examiner	d and cause Cause that resu	uentially list cor y, leading to me se. Enter Unde se (Disease or initiated events liting in death) L	imediate rlying injury	c	a consequence							
To the Hospital or Attending Physician: The law requires that the death certificate twithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b Medical Certification: To Be Completed by Physician/Medical	IF F 23b.	EMALE: Was decedent in the past 12 1 Yes 2 9 Unknown	pregnant months?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal deat		Ectopic pregnancy Other (specify)				23d. Date of Month	delivery Day Year
w requires that is been signed is should be det	Fait	II. Other signif	icant conditions co	entributing to death b	ut not resulting	in the u	nderlying cause give	en in Part I.	23e. Did t			te to the cause of death? Probably 4 Unknown
rician: The law requires cartificate has been s lirector, page 2 should	-								24a. Was autor perio		prior	e autopsy findings available to completion of cause of h? Yes 2 \sum No
ysician: is certifica director, p	25. \	Was case references	red to medical					26. Place of Deat		1.0		163 20110
this call dire		ZŽYes 2□	INO	Hospital:		_		4 Nursing Ho				Specify) at scene
ending Feath. or: After the funer	1	Manner of Death Natural Accident	5 Pending investigation	28a. Date of Inju (Month, Da)	y Year)	Time of Injury	Worl	yat k? Yes 2 ØNo	28d. Describe	now inju	Short	7
To the Hospital or Attending Phyship 24 hours after death. To the Funeral Director: Attenth completely filled in by the funeral Medical Certification:		SUSUICIDE	6 Could not be determined	28e. Place of Injubulding, etc.	c (Snacity)		eet, factory, office		28f. Location (: City or Tou 1745 /Form	vn, State	e)	Rural Route Number,
the Hospit in 24 hour the Funera pletely fills	29a.	Certifier (Check only one)	1□ Certifying Phy ∠Xi Medical Exam	rsician: To the best iner: On the basis of and manner sta	of my knowledg f examination a	e, deati	n occurred at the tim	ne, date and place,	and due to the red at the time,	cause(s date and) and manne	r as stated.
within To the compl	29b.	Signature and	title of certifier	1	10-		29c. License	number		29d. Da	te signed (M	fonth, Day, Year)
Vi		le	hill	as #	-\ -		0.0	C.M.E.		Ju	1y 15,	, 2005
1K	30. N	Vame and address		ompleted cause of d		(Туре, 11	Print) 1 Penn St	reet, Bal	Ltimore	, Ma	ryland	1 21201
State Registrar	31, [Date filed (Mont	h. Day. Year) JL 19 20	32/Aegistra	ar's Signature	fo	ede					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month i 8 Year 159 AM JAMES POWELL July 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HUSPITAL Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 13, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 € M 2 □ F 577-05-7165 Director 1914 Tennessee Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ "" any injury or other traumatic even." 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick 1 ☐ Yes 2 ☐ No New Market 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 7005 Fox Chase Crossing 21774 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No þ Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chief of Police US Capitol Police 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Milton Thomas Powell Aurora Ethel Ralston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Powell (Son) 11206 Jon Court, Ijamsville, Maryland 21754 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 7/22/2005 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ature of Fundral Service ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final THROMBOTIC PURPURA Physician THROMBOLY TO PENIC DAY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and the purial-tr resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 🗌 Yes 2No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2[**X**No 1 🗌 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Fo the 29c. License number 29b. Signature and Itle of 29d. Date signed (Month, Day, Year) JULY 18, 2005 D0061083 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9707 MEDICAL CENTER DRIVE, #700, ROCKVILLE, MD 20890 HALL THAMBI, 31. Date filed (Month, Day, Year) Registrar's Signature Registrar 2 0 2005

State of Maryland / Department of Health and Mental Hygien 2005 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^D**1**15, **Physician** Helen Bernadette Juliy Rosier 2005 5:52A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death La Plata

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth

Months | Days | Hours | Min. | Martin Pay 4,1946 Medical Center Civista Charles 5. Social Security Number 7. Age (In yrs. last birthday) 59 Yrs. **Funeral** 9. Birthplace (State or Foreign Maryland 1 ☐ M 2 🗓 F Months 217-46-8735 Director Usual Residence of Decedent death with the Maryland 10a State 10b Counts 10c. City, Town or Location itam 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic avant. Its Modical Examiliar must be notified at 10d. Inside City Limits MD Be Completed by Funeral Director Charles Newburg 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9609 Crain Highway 20664 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itan any injury or other traumatic avant, the Modicul Exami 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Black 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Care Giver Private 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Alexander Chase Catherine Olivia Smoot 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa Woodland/Daughter 9609 Crain Highway, Newburg, MD 20664 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ` 4 ☐ Donation 5 ☐ Other (Specify) Ignatius Cem. 7/19/05 Port Tobacco MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
AREHART-ECHOLS FUNERAL HOME, P.A. Echo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, MD 20646 shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ovarian Cancer /Medical Due to (or as a consequence of): Examiner Pleural Effusions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit Anemia attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 20 No
9 Unknown 3 Ectopic pregnancy Month 4☐Pregnant at time of death Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 XNo Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of After Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To tha Funaral D 29a. Certifier 1 XCertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ZEI OU 128035 07-18-2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Basirmohmad Kolia, M.D. 9135 Piscataway Road, Suite 210, Clinton, MD 31. Date filed (Month, Day, Year)

JUL 2 0 2005 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JULY 2005 Pear **19**′. ENA JENNINGS RABSATT 4:45 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BRYANS ROAD CHARLES 2332 SOUTH HAMPTON DRIVE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Figure 16, 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 1941 | 19 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 1 F 64 Director 580-09-4055 Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show itam 27 is markad othar than "natural", or Itams 23s or 28a-f shov other traumatic evant, the Maxical Experiment and the notified at 1 ☐ Yes 2 1 No Director MARYLAND CHARLES BRYANS ROAD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2332 SOUTH HAMPTON DRIVE 20616 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Be Completed by Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 121H GRADE and Mental Hygiene. College (1-4or 5+) COOK EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be f and Mental I ALEXANDER JENNINGS ROSELPHINE AGUSTA MADURO JENNINGS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MELISSA R. JOSTAH / DAUGHTER 2332 SOUTH HAMPTON DRIVE, BRYANS ROAD, MARYLAND 20616 it of Health 20a. Method of Disposition

1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 ŏ permit. Page Department of Important: If any injury or once. JULY 28, 2005 ST. THOMAS, U.S.VIRGIN ISLAND WESTERN CEMETERY * 4 □ Donation - 5 □ Other (Specify) nature of Funer I Semplicersee THORNION FUNERAL HOME, P.A. LADIA C. THUNNION JOHNSON MO0583 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** K Mouris /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE esn If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖪 No Month Year Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has 2 No 1 ☐ Yes To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 🔀 No Certification: To 1 Tyes 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury investigation 1 Tes 2 No 2 Accident after death Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE WATHEN, M.D. 11345 PEMBROOKE SQUARE, SUITE 103, WALDORF, MARYLAND JUL 2 0 31. Date filed (Month, State 2005 Registrar

			1 - For State of Maryland / Dep Registrar Ce	artment of Health and I		piene 2005 25393
			Decedent's Name (First, Middle, Last)		2. Date of Deat	
	Physic		Debra Lynn Leadbetter Ryan		Month July	Day Year
	/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		25, 2005 12:16 P M
			19783 Sams Way	Lexington Park		St. Mary's
	Funeral	Г	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
	Director		578-98-7057 1□M 2 X F 40 Yrs.	Months Days Hours Min.	May 8,	1965 Maryland
	pug *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo			
	farylan show	5	1000 000,7 10000 01 20			10d. Inside City Limits
	28a-1	Director	Maryland St. Mary's Lexingt	on Park		1 ☐ Yes 2 X No
	with a or	급	19783 Sams Way	10f. Zip Code	1	0g. Citizen of What Country?
	eath	Funeral		20653		U.S.A.
	fter d	F	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	 Race - American Indian, Black, White, etc.
21215-0036	within 72 hours after death with the Maryland ene. than "natural; or items 23a or 28a-f show he Madical Exeminat must be neithed at	by		1 ☐ Yes 2 ☑ No Specify:		Specify: White
0	2 ho	Completed	15. Decedent's Education 16a. Dece	dent's Usual Occupation		16b. Kind of Business/Industry
7	lhin 72 ho e. an "natu	ple	(Specify only highest grade completed) (Give life.	kind of work done during most of work DO NOT use retired)	ring	
7	77 75 6	5	12 Waitr	ess		Restaurant
pu		Be (17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, M	
<u>yla</u>		2	Jerry Braxton Leadbetter	Helen A	itcheson	Longanecker
Maryland	2 should be and Ment is marked	1 3	19a. Informant's Name/Relationship (Type, Print)	ng Address (Street and Number or Rur	al Route Number,	City or Town, State, Zip Code)
	1 and 2 Health Iam 27 i		Helen Bergling/ Mother 1978	3 Sams Way, Lexin	gton Parl	k. MO 20653
Ore	ges 1 and 2 should it of Health and Mer it itam 27 is marks or other traumatic		ZOA, MELIOU DI DISDUSITION I ZOD, FIACE DI DISDO	sition (Name of matory or other place)	Date 2	20c. Location - City or Town, State
Ē	ment mant: lant:		`4 □ Donation 5 □ Other (Specify) Brinsfiel	d-Echols Cre 7-27		harlotte Hall, MD
Baltimore,	permit. Pages. Department of H Important: If its any injury or of		21. Signature Livense 22	. Name and Address of Facility Br	insfield	Funeral Home, P.A.
_	7 □ = 8 0			2955 Hollywood Ro		
п		ū	23a. Part1. Enter the disease, or complications that crused the death. Do not ent shock, or heart failure. List only one cause, in each line.	er the mode of dying, such as cardiac	or respiratory arre	st, Approximate Interval Between
	Priysician .	e n	Immediate Cause (Final disease or condition	Esophage	al C	ance 2 Onset and Death
	/Medical Examiner	П	resulting in death) Due to (or as a consequence of):			
		_	Sequentially list conditions, b.			
	ed isit	iner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	and and Il-trar	Examin	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
8760,	icate be executed physician and the burial-transit	alE	Due to (of as a consequence of).			
	icate phys s the	dlcal	d			
×	death certifi e attending ed for use as	Physiclan/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			
Вох	atter for u	clar	in the past 12 months? 1 Live birth 2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
O.		ıysi	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		,
S, D	requires that the	by Pt	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
rds	uires n sign					2 □ No 3 ☑ Probably 4 □Unknown
Record	> 0 0	lete			24a. Was an	
Be	0 5 0	Completed			autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
	ician: Th certificate rector, pag	0	25. Was case referred to medical		1 ☐ Yes 2[INo 1 ☐ Yes 2 ☐ No
>	Attanding Physician: r death. actor: After this certific by the funeral director.	0 0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	26. Place of Death		
o	ding Phy h. After this funeral c	\vdash	27. Manner of Death 28a. Date of Injury 28b. Time of	3 DOA 4 Nursing Hor	ne 5 Mesiden 28d. Describe how	ce 6 Other (Specify)
<u>o</u>	ath. r: Aft	atlo	1 Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		an, and a second
Division of	or Attand after death Diractor: A in by the fi	III C	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stre	et, factory, office	28f. Location (Stre	eet and Number or Rural Route Number,
ā	ō = 5 ⊆	Certification:	4 ☐ Homicide building, etc. (Specify)		City or Town,	State)
	To tha Hospital within 24 hours a To tha Funeral E completely filled		29a. Certifier Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, a	and due to the cau	ise(s) and manner as stated.
	ha H in 24 ha F plete	edical	(Check only one) Medical Examiner: On the basis of examination and/or invitable and manner stated.	estigation, in my opinion, death occurre	ed at the time, date	e and place, and due to the cause(s)
	To tha within 2 To tha complet	Σ	29b. Signature and title of gertifier	29c. License number	290	d. Date signed (Month, Day, Year)
1			rapide Cres mo	D4172	8	7/26/05
2	5	Ì	30. Name and address of person who completed cause of death (Item 23a) (Type, F		,	- ///-
7			Patrick Cross, 24035 Three Notch Ro		ryland 2	0636
	Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signature	L. K.		
	Registra	ir (JUL 2 7 2005			

State of Maryland / Department of Health and Mental Hygiene

					,	Cert	ficate of	f Death		Reg. N	·2 N	05	25201	١.
	Dhysisi		1. Decedent's Name (First, Middle, Last,						2. Dete d	of Deeth	еу	Year	3. Time of Death	4
	Physici /Medic		James Elwood Ri						July	20	2005		11:00 PM	
فخمسه	Examin	er	4a Fecility Name (If not institution, give Avalon Manor Nurs						wn, or Location of [c. County			
	Funeral		5. Social Security Number 6. Sec		(In yrs. lest bi		If Under 1 Yea			of Birth h, Dey, Yea		ington 9. Birthplace	e (State or Foreig	วูก
	Director			M 2□F	55	Yrs.	Months Day	s Hours	Min. (Mont) Sep.	1, Dey, Yea.	949	Mary I a	nd	
	Pu »		Usual Residence of Decedent 10a. Stete 10b. County		10c. City, Tov	wn or Loca	tion			-		104	Inside City Limit	_
	Aanyle Fehor	5					tion					1	1 ☐ Yes 2 💆 N	
	28a-	Director	Maryland Washingt 10e. Street and Number	on	Hagers	STOWN	10f. Zip Code			10g. C	itizen of \	What Country	?	
	h with	<u>e</u>	17340 Claymont Dri	ve			21740)		US	A			
	- deat	Funeral		12. Was Decedent E Armed Forces?	ver in U,S.	13. Wa			gin? (Specify Yes o		14. Rac	ce - American		
21215-0020	ges 1 and 2 should be filed within 72 hours aftar death with the Marylend tof Health and Mantal Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	۾	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:	0		Yes 2⊠N				Specity			
15-(natu natu	Completed	15. Decedent's Edu (Specify only highest grad	cation completed)	168	(Give kit	nt's Usual Occi nd of work don NOT use retii	e durina most	t of working	16b.	Kind of Bu	usiness/Indus	try	
12	2 should be filed withir and Mantal Hygiene. Is marked other than sumatic event, the Manada and	E C	Elementary/Secondary (0-12)	College (1-4or 5+	-		ty Engi	,		Ph	o re mod		al Comp.	
Þ	should be filed within and Mantal Hygiene. a marked other than sumatic event, the Mana	Be C	17. Father's Name (First, Middle, Last)	4		CIII	ry_Engl		er's Name (First, Mi				ar comp.	
ylar	uld be Manta irked itic ev	2	Marion Francis Ric	kard	12			Jane	Elizabet	h McC	auley	y		
Man	2 sho and is me		19a. Informant's Name/Relationship (Ty			_			er or Rural Route N					
e, l	1 and 1 Health em 27 other tr	-	Suzanne Rickard 20a. Method of Disposition	(Wife)	Y		Claymor ion <i>(Name of</i>	it Dr.	Hagersto	-		and 21 City or Town		_
Baltimore, Maryland	pemit. Pages 1 and Department of Health mortant: If item 27 any injury or other th		1 ☐ Burial 2 ☐ Cremation 3 ☐ F	emoval from State	cemete	ery, crema	tory or other p	·	l I			-		
ıtin	permit. Pa Departmen Important: any injury once.	1	4 ☐ Donation 5 ☐ Other (Specify) 21. Sign thre ☐ heral Service Licens	A	SMITH	22 N	Jame and Add	ress of Facilit	uly 22,20			1,200	11/2	=
ä	Per Impa		Dutel	Me		WII	llamspo	ort, Ma	Home P.A	21/95	s. c	Conococ	heague	S†
may.			23a. Part1. Enter the diseese, or complishock, or heart failure. List only or	cations that caused to e cause on each line	the deeth. Do e.	not enter	the mode of dy	ying, such as	cardiac or respirato	ory arrest,		Int	proximate terval Between aset and Death	
J.	Physician /Medical		Immediate Cause (Final	14	- 100	16:	•	l vm	chom.	4				
	Examiner		disease or condition resulting in death)	. 41	Due to (or as a	conseque	nce of):		,	1 40	-2	1		
	D #	iner		1	ver.	H	dgel	4i w	show.	Mar	n ci	1		
•	icata be executed physician and s the bunal-transit	Examiner	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury	C	oue to (or es a	conseque	nce of)							
68760,	s be e siciar e buri		that initieted events		ue to (or as e	CORSAGIJA	nce of):					1		
89	ertificat ling phy e as th	Medicai	resulting in death) Last		40 10 (0. 40 0	001100400								
Вох	aath cert attandin I for use	an												_
0	it the dae by the a stached f	Physician/	Part II. Other significant conditions con	tributing to death but	not resulting	in the und	ertying cause g	jiven in Part I.					e cause of death	
<u>α</u>	es that the igned by be detact	됩								1 🗌 Yes	2□ No	3 Probab	ly 4 triknoi	WIT
Vital Records,	The law requires that the death certificate be executed to has been signed by the attending physician and pege 2 should be detached for use as the bunal-transit	Completed by	-							Was an auto performed?	opsy	availal	autopsy findings ble prior to etion of cause th?	
Re	The law ate has pege 2	Ē								1 Ves 1	2 7 10	1 🗆 Y	es 2□ No	
ita		Be C	25. Was case referred to medical examiner?					26. Place	of Death (Check o	nly one)				
of \	hys H di	ှု	1 Yes 2 No	ospital: 1 Inpatien	-	-	3LI DUA		rsing Home 5 1					_
nc	ding P h. After 1 funer	틸	27. Manner of Death 1 Natural 5 Pending investigation	28e. Date of Injury (Month, Day		Time of Injury	28c. Inj W	uryat onk? ⊒Yes 2.∐l		ribe how inj	ary occurr	:ea		
Division	i or Attending after death. Director: After d in by the fune	Certification:	3 Suicide 6 Could not be	28e. Plece of Injur	y - At home, fa	arm, stree	t, factory, offici	9				er or Rural R	oute Number,	-
ă	s after al Direction by	Cert	4 Homicide	building, etc.	(Ѕреспу)				City of	r Town, Sta	θ)			
	To the Hospital or I within 24 hours after To the Funeral Director Complately filled in b	edical	(Check only 2 Medical Examir		examination ar									
	ithin 2 orthe	8 ∑	one) 29b. Signature and title of cedifier	and manner state	9d.		29c. Licer	nse number		29d. D	ate signer	d (Month, De)	r, Year)	
	or verification of the contracti		1 tand	Jum			0	0060	396	-	7 2	21/05		
		-	30. Neme and eddress of person who co				int) 1	126	08 61	er	`		2 .	
2	-12		+ARID	MUN		()			Hayer	tod v	¥ , ¥	MO	21140	_
	Sta	е	31. Date filed (Month, Day, Year)	32. Registrer	's Signature	Do	ede		O					

1		1	For State Registrar	State of	Maryland		artment rtificate			and M	ental Hy	giene	005	25395		
			1. Decedent's Name (First, Mide	dle, Last)							2. Date of Dea			3. Time of Death		
	Physici /Medic		Thomas	Henry	Ratliff	Jı	: .				JULY_1		05 Year	12:00 P ^M		
	Examin	_	4a. Facility Name (If not instituti		oer)		4b. City, T					4c. County of Death				
	Section 1		9028 DAVIS RO				SBURG				COMICO					
	Funeral		5. Social Security Number	6. Sex 7. 1 1 ★ 2 ☐ F	Age (In yrs. last	t birthday) Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da)	y, Year)	9. Birthr	place (State or Foreign ntry)		
6.1	Director	}	405-22-1158 Usual Residence of Decedent		80			1			4/6/1	925	West	Virginia		
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Itema 23a or 28a-f ahow other traumatic avant, the Medical Exemplish must be notified at		10a. State 10b. Count	ty	10c. City, T	Town or Lo	ocation							10d. Inside City Limits		
		ctor	Maryland Wicomico Salisbury										1 ☐ Yes 2 🛣 No			
		Funeral Director	10e. Street and Number		10f. Zip 0			10g. Citizen	of What Coul	ntry?						
		rai	3975 Trace Ho		21804							4				
		une	11. Marital Status	ent Ever in U.S. es?	 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 						 Race - American Indian, Black, White, etc. 					
36		by F	1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No 1 □ Yes 2 ☑ No Specify: 1 □ Yes 2 ☑ No Specify:							Specify: white 16b. Kind of Business/Industry						
21215-0036	"natural",	ted														
215	hin 7	pie	(Specify only high Elementary/Secondary (0-12)	nest grade completed) College (1-4	lor 5+)	life.	kind of work DO NOT use	e retired)			rg					
	ed wi	Completed	12	4+		Mecr	nanica					NAS				
Ind	tal High doth	Be	17. Father's Name (First, Middle Thomas Henry F					1			(First, Middle, ne Coll:	Middle, Maiden Sumame)				
yla	t. Page rtment c rtant: If njury or	2	-			405 14-11	6 4 /					LLINS umber, City or Town, State, Zip Code)				
Maryland			19a. Informant's Name/Relation Rebecca Ratlif				-				, Salis					
			20a. Method of Disposition	,	20b. Plac	e of Dispo	sition (Name	e of			ate		on · City or To			
OL			1 ☐ Burial 2 🔀 Cremation 4 ☐ Donation 5 ☐ Other		ate i		matory or oth ry Crer			7/21/	05	Salis	bury,	MD		
Baltimore,			21. Signature of Funeral Service	1										sociation		
ä	Depa Impo any Ir		NURL	Wenn	CFSF	9 5	01 Sno	ay r ow H	unera ill R	g.	me Pro Salisbu	ressio urv. M	nal As D 2180	sociation 4		
F. C.	Physician /Medical Examiner Physician	icai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Onset and Death Due to (or as a consequence of): b. Due to (or as a consequence of): C. Due to (or as a consequence of):											Silst and Death		
P.O. Box 68760,	or Attending Physician: The law requires that the death certific death. Director: After this certificate has been signed by the attending policetor: After this certificate has been signed by the funeral director, page 2 should be detached for use as	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									23d. Date of delivery Month Day Year				
		þ										cco use contribute to the cause of death?				
al Records,		e Completed	25. Was case referred to medic	ral .					26 Place	of Dooth		med? 2 No	b. Were auto prior to co death? 1 X Yes	psy findings available mpletion of cause of 2 No		
Vital		ToB	examiner? 1 Yes 2 No	Hospital:	patient 2□ER	VOutpatier	26. Place of Death (Check only one) Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 ★ Other (Spe							v) SCENE		
Division of		Certification; T										one built				
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (tated the cause(s)				
	To the To the Comp	Σ	29b. Signature and title of certif	ier	100 .		29c.	License	number			29d. Date sig	gned (Month,	Day, Year)		
	in mp.		retul	in -t	Olleh	- me		(CME			JULY 2	20, 200)5		
	IVA		30. Hame and address of person	tronica-	SHAK	M	\ 111		N STR	EET,	BALTIM	IORE, 1	MARYLAN	ND, 21201		
1	Sta Registr		31. Date filed (Month, Day, Yea	2 1 2005 32. R	istrar's Signatur	K A	barle	,								

		Plea	-	-			delible Ink.			-			.egible	e.			
		For	;	State o	of Maryla	-	artment of F		ind M	ental H	lygi	ene					
		= State Registrar	Ce	rtificate of		Reg. N6			253	96							
Physicia	an	Decedent's Name (First, Middle		,	_						2. Date of Death Month E			ar 3. Time c	of Déath		
/Medic		Abdullahi		ohame		Ragi				7/	16		2005		рм		
Examin	er	4a. Facility Name (If not institution					4b. City, Town, o		f Death				County of E				
		Prince Georg 5. Social Security Number	es h	lospi			Cheverl If Under 1 Year	- Y If Under 2	24 Hrs.	8 Date of				George:			
Funeral Director		5. Social Security Number 6. Sex 1 \times 0 Age (In yrs. last birthday) 1 Under 1 Year 1 Under 2 \times 0 Age (In yrs. last birthday) 1 Under 1 Year 1 Under 2 \times 0 Age (In yrs. last birthday) 1 Under 1 Year 1 Under 2 \times 0 Age (In yrs. last birthday) 1 Under 1 Year 1 Under 2 \times 0 Age (In yrs. last birthday) 1 Under 1 Year 1 Under 2 \times 0 Age (In yrs. last birthday) 1 Under 2 \times 0 Age (In yrs. last birthday) 1 Under 1 Year 1 Under 2 \times 0 Age (In yrs. last birthday) 1 Under 2 \times 0 Age (In yrs. last birthday) 1 Under 2 \times 0 Age (In yrs. last birthday) 1 Under 2 \times 0 Age (In yrs. last birthday) 2 \times 0 Age (In yrs. last birthday) 1 Under 1 Year 1 Under 2 \times 0 Age (In yrs. last birthday) 2 \times 0 Age (In yrs. last birthday) 1 Under 2 \times 0 Age (In yrs. last birthday) 2 \times 0 Age (In yrs. last birthday) 2 \times 0 Age (In yrs. last birthday) 2 \times 0 Age (In yrs. last birthday) 2 \times 0 Age (In yrs. last birthday) 2 \times 0 Age (In yrs. last birthday) 2 \times 0 Age (In yrs. last birthday) 2 \times 0 Age (In yrs. last birthday) 2 \times 0 Age (In yrs. last birthday) 2 \times 0 Age (In yrs. last birthday) 3 \times 0 Age								8. Date of (Month, 11/4	Day, 1	(ear)		Birthplace (State Country) SmaliaA			
	Director	Usual Residence of Decedent													LLLCc		
wo H		10a. State 10b. County 10c. City, Town or Location													10d. Inside City Limits		
a-f s		VA Prince William Woodbridge 109. Street and Number 109. Street and													2 ∑ No		
a or 28a-f show		10e. Street and Number	_	10g. Citizen of What Country?													
238 ust t	rai	3001 Hospital Drive 20785										U.S.A.					
tems ar m	Funerai	11. Marital Status	U.S. 13.	Was Decedent of H If Yes, specify Cuba	cify Yes or Rican, etc.)	14	14. Race - American Indian, Black, White, etc.										
or		7.5	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:								Specify: black						
iurai al Ex	ed by	3 Widowed 4 Divorced			I 160 Door	dent's Usual Occup		16b. Kind of Business/Industry									
n na	Completed	(Specify only highe				/ Give	kind of work done DO NOT use retired	durina most	of workii	ng	160. Kind of Business/Industry						
than than	ф	Elementary/Secondary (0-12)		al Manager						Restaurant							
Hygi sther	ပိ	17. Father's Name (First, Middle,	Last)						r's Name	(First, Midd	ile, Ma	aiden S	iumame)				
kad c	To Be	Mohamed Ra	gis					Sala	aado) Hu	SS	sen Osman					
mar mat	μ.	19a. Informant's Name/Relations		e, Print)		19b. Mail	ing Address (Street	and Number	r or Rura					-	22041		
Department of Health and Mental Hygiene. Important: or Items 23a or 28a-f show Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Mohamed Abdu	llah	i/co	usin	5505	Seminar	y Rd.	.,Ap	t#40	3 1	Fal	ls C	-			
f Headitem othe		20a. Method of Disposition		-		Place of Disp	osition (Name of matory or other place	20		ate	20	c. Loc	ation - City	or Town, State			
int: if		1 Magazial 2 ☐ Cremation 1 Donation 5 ☐ Other (S		moval from			Lim Ceme	1//	/20/	2005	St	taf	ford	, VA			
orta inju		21. Signature of Funeral Service	icensee	111	-/-				Uni	vers	al	Мо	rtua	ry			
Depa Impo any ii		21. Signature Funeral Service Licensee 22. Name and Address of Facility Universal Mortuary 411 Kennedy St., N.W. Washington, DC 20011													0011		
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between															
nysician		Immediate Cause (Final	orny orne	CI	MITE	1000	mowh	1 SAC	<	tral	0			Onset and			
Medical		Immediate Cause (Final disease or condition resulting in death) a															
xaminer		Companie II. Has an additional															
-		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying)	Due to	(or as a conse	quence of):								3			
sicien and burial-transit	Examiner	Cause (Disease or injury that initiated events	c.	с													
icien a burial-		resulting in death) Last		Due to (or as a consequence of):													
attending physic	an/Medicai		d.														
nding phys	Mec	IF FEMALE:	0						_			T					
e attend ad for us	lan/	23b. Was decedent pregnant in the past 12 months?	230	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy							23d. Date of Month				Year		
⊕ ⊆	Physici	1 Yes 2 No		4☐ Pregnant at time of death 5☐ Other (specify)9☐ Unknown													
ad by detac		Part II. Other significant condition	23e. Di	23e. Did tobacco use contribute to the cause of death?													
ite has been signed by the a page 2 should be detached f	d by										1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknow						
been s	ompieted									04-145			-		ilabla		
has b	mpi									24a. Wi	topsy	1	240. were prior death	autopsy findings to completion of o	available cause of		
	Ö											performed? death? 1 ☐ Yes Ø No 1 ☐ Yes 2 ☐ No					
this certificate has ral director, page 2	Be	25. Was case referred to medica examiner?		spital:			nt 307 DOA Oth	or		(Check onl		_			_		
this ral diii	2	1 Yes 2 No 27. Manner of Death		28a. Date		ER/Outpatie	5 <u></u> 50 <i></i>	4 🗀 (140)		ne 5 🗌 Re !8d. Describ				Specify)			
h. After funei	ertification:	1-Aatural 5 ☐ Pendir		(Mon	th, Day Year)	Injury	Wor	yat k? Yes 2 □ N			2	jw1 y					
deat ctor: y the	fica	3 Suicide 6 Could not be 380 Place of Injury 4t home farm street factory office 28f Lor										Location (Street and Number or Rural Route Number,					
Dire Dire	erti	4 Homicide determ	mieu	build	ing, etc. (Spec	eify)				City or 1							
nours neral	0	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													5)		
withir To th somp	Me	29b. Signature and title of certifie		29c. Licens	29d. Date signed (Month, Day, Year)												
		1/4					D22950					7/16/05					
25		30. Name and address of person	who com	pleted caus	se of death (Ite	em 23a) (Type,	Print)										
=		2001 110	20.	And)	Dn 11	10 B	Loutondi	1	10	207	85	_ ጥረ	arri	Matin			

State Registrar

			rieas	State of M		partment of H			•	
			For State Registrar	State of M	•	ertificate of l			2005	25397
			1. Decedent's Name (First, Middle,	Last)				2. Date of Death	h Day Year	3. Time of Death
	Physici /Medic		Marjorie Rita R	ailey				July 16,	2005	2:00 A. M
	Examin		4a. Facility Name (If not institution,	give street and number)			Location of Death	h	4c. County of Dea	
			Glade Valley N		Annual to Albinda	Walkersv:	ille If Under 24 Hrs.	O Data of Birth	Frederi	
	Funeral Director		5. Social Security Number 220-94-0841 Usual Residence of Decedent	5. Sex 7. Ag	ge (In yrs. last birthd 80	Months Days	Hours Min.	(Month, Day,	Year) 9. Bi 1925 Was	rthplace (State or Foreign ountry) hington, D.C.
	land		10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	Se-f eh	ctor	Maryland Frede	rick	Frede					1 Tes 2 No
	23a or 2	al Dire	10e. Street and Number 11589 Liberty O	ak Drive		10f. Zip Code 21701		10	U.S.A.	ountry?
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other then "natural", or Iteme 23a or 28e-f ehow or other treumatic event, the Medical Examinar must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Vidowed 4 Divorced	12. Was Decedent Armed Forces? Id 1 Yes 2 If Yes, Give Year or Dates:	Ever in U.S.	 Was Decedent of H. If Yes, specify Cuba Yes 2√ No 	ispanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh Specify:	
Maryland 21215-0036	hin 72 ho s. sn "natur Medical i	pleted	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed)	(G	ecedent's Usual Occupa live kind of work done of e. DO NOT use retired	ation during most of wor)	rking	16b. Kind of Busines	s/Industry
217	giene giene r the	E O	_11	College (1 4c)		emaker			Own hom	e
land	i 2 should be filed within " n and Mental Hygiene. r is marked other then " reumatic event, the Med	To Be (17. Father's Name (First, Middle, L Frederick Burr					me <i>(First, Middle, N</i> rine Hous	,	
	nd 2 shoilith and A 27 is ma		19a. Informant's Name/Relationsh Cathy Strouth -			ailing Address (Street a				Zip Code) aryland 21701
Je,	s 1 ar		20a. Method of Disposition		20b. Place of Di	sposition (Name of crematory or other place	e)	Date 2	20c. Location - City o	r Town, State
E	Page nent c ant: ff		1 ☑Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (Sp			ham Cemete:		-2005 Ch	eltenham,	Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health s Importent: if Item 27 is any injury or other tre		21. Signature of Funeral Service L	icensee	110	22. Name and Address		Stauffer ike, Fred	Funeral H	ome ryland Approximate
	Physician /Medical Examiner	ler	3a. Part1. Enter the disease, or o shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause Enter to 33 miles.	a Due to (or as	ine.	er of	.	/	est,	Approximate of the control Between Onset and Death MONTUS
Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	n/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	d23c. If yes, outcome					23d. Date of de	slivery
o.	that the death ed by the atte detached for	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 ☐ Fetal death t time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
rds, P.	w requires that been signed b should be det	by	Part II. Other significant condition			e underlying cause give	en in Part I.	23e. Did tob		to the cause of death?
Il Records,	yeicien: The law requis certificate has been director, page 2 should	Completed	Hipy	Fractur	<u>-e</u>			24a. Was ar autopsy perform 1 Yes 2	y prior to	autopsy findings available completion of cause of
Vital	cien	Be	25. Was case referred to medical examiner?	Hospital:		Cth		ath (Check only one	-	
of	> .∞ 0	٦. ام	1 Yes 2 No 27. Manner of Death	1 Inpati		itient 3 DOA	gursing H	fome 5 Reside	nce 6 Other (Spewinius)	ecify)
no	ling After Tune	Certification;	1 □Natural 5 □ Pending 2 Accident investig	(Month, Da	y Year) Inju		K? V	E-11	411:2	1.1.12:
Division	Attendi death. ctor: A	flca	3 ☐ Suicide 6 ☐ Could no	V AS	jury - At home, farm	, street, factory, office		28f. Location (Str	reet and Number or F	Rural Route Number
Ö	after Dire d in b	erti	4 Homicide	building, e	tc. (Specify) Home			City or Town	State)	Frederick MD
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the best xaminer: On the basis of and manner st	of my knowledge, d	eath occurred at the time investigation, in my o	ne, date and place pinion, death occu	a, and due to the caurred at the time, da	use(s) and manner a	s stated. e to the cause(s)
	Fo the within Fo the Complex c	Me	29b. Signature and title of certifier			29c. License	a number	25	d. Date signed (Mor.	th, Day, Year)
) (Elan	Kaliro	MI	DI	37197	>	7-19-	2005
	2		30. Name and address of person v	no completed cause of	death (Item 23a) (Ty	pe, Print)	71/2 -	,	1	-MO 21701
			Hlan Kol	ver, M	D 13	West/	5%	reet tr	cherick	-MO 21701
	Sta Regista		31. Date filed (Mong) Play, 2 ar	ZUU5 32 ogist	rar's Signature	garde .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

M			1 - State	State	of Maryla		artment of F <i>rtificate of</i>	lealth and N Death			_	
7	9	7.7	Registrar 1. Decedent's Name (First, I	Middle, Last)		- 00	runcate or	Dealli	2. Date of Dea	Reg. No.	05 -	25398
	Physic /Medi		Daniel Jon	es Rapp					July	Day	2005	0338 M
in the second	Exami		4a. Facility Name (If not inst		,		4b. City, Town, o	r Location of Death		1	y of Death	
		* -	Route 70 @ M				Myersv:			Fr	ederi	ck
75	Funeral Director		5. Social Security Number 080-56-0864	6. Sex 1 X M 2 ☐ F		rs. last birthday) 45 Yrs.	Il Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Apr. 13	Year)		place (State or Foreign ntry) York
	fand wo		Usual Residence of Deceder 10a. State 10b. Co		10c.	City, Town or Lo	cation					10d. Inside City Limits
	Mary Ind	ţō	Maryland Mon	toomerv	Roy	ckville						1 ☐ Yes 2 🛣 No
	or 28s	lrec	10e. Street and Number	2801110119	1101	CKVIIIE	10f. Zip Code		1	10g. Citizen of	What Cour	ntry?
	23a c	alD	12709 Parkla	nd Drive			20853		Į	JSA		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: if Item 27 is marked other than "naturel", or Iteme 23a or 28a-f ehow eny injury or other traumatic event, "the Madical Examinar must be notified at 005e.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 3 □ Widowed 4 □ Divo	Married 1 Tyes	ecedent Ever in Forces? s 2 X No Give Dates:		Was Decedent of H if Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Rad Bla Specif	ce - Americ ck, White, y: Whi	etc.
2-0	72 ho	ted	15. Dec	edent's Education	er)	16a. Dece	dent's Usual Occup	ation		16b. Kind of B		
21	within 7 ene. than "r	nple	Elementary/Secondary (0-	ighest grade completed 12) College	(1-4or 5+)	life.	kind of work done on DO NOT use retired	ation during most of work f)	ing .			,
121	filed w Hygier Ather th	Sor	17 Sahada Nasa (***********************************	3		Produ	ction Pla			Printi		mpany
Maryland	ould be fi Mental H arked ot atic ever	Be	17. Father's Name (First, Mic Stuart Everly					18. Mother's Name		Maiden Suman	10)	
2	2 should and Me is mark sumation	욘	19a. Informant's Name/Rela		_	10h Mailie	Address (Chase	Rhode An		-		
	1 and 2 s Health ar Iom 27 is		Julienne M. I			12709	Parkland	and Number or Rura d Drive R	ockville	MD 2	State, Zip 0853	Code)
Baltimore,	Pages 1 a nent of He int: if item iry or otha		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremal 4 ☐ Donation 5 ☐ Othe	ion 3 Removal from	m State		sition (Name of natory or other place	٠,	, 20,	20c. Location -		
alti	permit. Pag Department Important: I eny injury o	İ	21. Signature of Funeral Ser		,			Second Facility Cremation				*
	82 = 9		Devely 7	Health		DI Be	verly L.	Heckrott	e. P.A.	Clarks	· box	, MD 21029
	Physician /Medical Examiner	ner	23a. Part1. Enter the diseas shock, or heart latiture. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any learning to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	a M Due to	each line type o (or as a consi	equence of):	we have a dynamic and the second	g, such as cardiac c	or respiratory arm	est,		Approximate Interval Between Onset and Death
68760,	rificate be executed ig physicien and as the burial-transit	fedical Examiner	resulting in death) Last	c. Due to	o (or as a conse	equence of):						
.O. Box	death cer e attendir d for use	Physician/N	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	utcome of preg birth 2 Fe gnant at time of nown	tal death 3	Ectopic pregnancy Other (specify)			23d. Dai Mo	te of deliver	ry Day Year
ords, P	en signed	ρ	Part II. Other significant con	ditions contributing to	death but not re	esulting in the ur	derlying cause give	in in Part I.			ribute to the	e cause of death?
al Record		Completed							24a. Was ar autopsy perform 1 Yes 2	y ned?	prior to com death?	osy findings available inpletion of cause of
Vital	Physician: 1 this certifice al director, p	o Be	25. Was case referred to med examiner? 1∑ Yes 2 □ No	Hospital:		7500	act now Othe	26. Place of Death			-	
of	ding Phys h. After this funeral di	\vdash \vdash	27. Manner of Death	28a. Date	of Injury	28b. Time of	3LI DOA	4 Nursing Hon	ne 5 Reside			Scene
Ö	Attending r death. octor: After	ate	1 □ Natural 5 □ Pe 2 Accident inv	runing	nth, Day Year)	Found	28c. Injury Work 1 □ Y	es 20 No	rosser	es vehi	el	yest -
Division	or Attendater deatl	Certification;		uld not be termined 28e. Plac	e of Injury - At ding, etc. (Spec	home, farm, stre	et, lactory, office	2	281. Location (Str	eet and Numbe	er or Rural	Route Number.
	ospital or hours afte unsral Dir ly filled in					cooding	4		City or Town	VIII 1	Lien /	Port 70
	Hospital 24 hours a Funeral dely filled	edical	29a. Certifier 1 ☐ Certi (Crock only 2 Medi	fying Physician: To the cal Examiner. On the tand man	e best of my kr	nowledge, death	o curred at the time	e, date and place, a	nd due to the ca	use(s) and ma	nner as sta	ited.
	e canada		one) 29b. Signature and title of cer	2.13 1.121	nner stated.		29c. License			d. Date signed		
-	75-0		The	. 11 7					23			
(1	20		30. Name and address of pers	son who completed cau	ise of geath (Its	m 23a) (Type F	OCME			July,	18, 20	005
)	6.9		THEODINE	Lickais	3 11			ltimore,	MD 2120	1		
**	Star Registra	٠,	31. Date filed (Month, Day, You JUL	2 1 2005 ³²	Registrar's Sign	nature			<u>.m 2120</u>	4		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Day Year **Physician** July 14 2005 3:10 Walter McGill Russell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Ctr. Westminster Carroll Carroll Lutheran Village Health Care If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** M 2□ F Yrs. Director 89 705-12-6755 March 7 1916 MD Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is markad other than "natural", or itams 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD Westminster 1 ☐ Yes 2 ☐ Mo **Funeral Director** Carrol1 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1778 Baltimore Blvd 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 SWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Glen L. Martin Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward Moore Russell Effie Beggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 si ment of Health an ant: If Itam 27 is 1776 Baltimore Blvd Westminster, MD Heidi Utz/granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 7/18/2005 1

Burial 2 □ Cremation 3 □ Removal from State ö Department of Important: If any injury or once. `4 ☐ Donation 5 ☐ Other (Specify) Meadow Branch Cemetery Westminster, MD 22. Name and Address of Facility
Pritts Funeral Home and Chapel, P.A. 21. Signature of uneral Se 21157 412 Washington Road Westminster, MD 23a. Part1. Enter the disease, or complications that caused the dust. h. Do not enter shock, or heart failure. List only one cause a each line. Approximate Interval Between Onset and Beath Immediate Cause (Final 5d. Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day be detached for 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 22 No 1 ☐ Yes 1 🗌 Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 2 Accident 28b. Time of Injury 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To tha Funaral Diractor: A completely filled in by the fu 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier | 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the I 29b. Signature and 25 who completed cause of death (Item 23a) (Type, Print) EVIN 688C +00L 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

			For Stete	State of Ma		nd / Dep	artmer	nt of H	lealth an	d Mental H		•	25400
			Registrer 1. Decedent's Name (First, Middle, I	aeti		Ce	rtificat	e or l	Jeath	2. Date of D	Reg. No	5.000	
	ysici			,						Month	Da	A A La Pro	3. Time of Death 5.00 AM
	Medic camin		Walter Shipman 4a. Facility Name (If not institution, g				4b. City,	Town, or	Location of D	Death Octo	40	2005 County of Deat	
	CONTRACT		Doctors Hospita	1			Lanh	am			P	rince G	eorges
	eral		5. Social Security Number 6.	Sex 7. Ag		last birthday)	If Under	r 1 Year Days	If Under 24 Hours	Hrs. 8. Date of B (Month, D 08/07/			hplace (State or Foreign untry)
Dire	ctor		579-46-7225 Usual Residence of Decedent	1 Divi 2 1	68	Yrs.				08/07/	1936	Peni	nsÿlvania
yland	18		10a. State 10b. County		10c. Cit	ty, Town or Le	ocation						10d. Inside City Limits
Mar a-t st	Hed	ctor	Maryland Prince	Georges	Sea	brook							1 XYes 2 ☐ No
ith the	20120	Funeral Director	10e. Street and Number				10f. Zip	Code			10g. Ci	tizen of What Co	untry?
ath w	ust	rall	9403 Wellington		-		207				USA		
ter de	CIELL	une	11. Marital Status 1 ☐ Never Married 2 ☼ Married	12. Was Decedent Armed Forces?		.S. 13.	Was Dece If Yes, spe	dent of Hi cify Cuba	ispanic Origin n, Mexican, F	? (Specify Yes or Nuerto Rican, etc.)	10-	14. Race - Ame Black, White	
urs al	Exain	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 🗆 Yes	2 X No	Specify:			Specify: Wh	ite
III.Q. Z. I.Z. I.J. OUGGO be filed within 72 hours after death with the Maryland tale Hyglene. do other Han "natural", or ttems 23a or 28a-f show	dical	Completed	15. Decedent's (Specify only highest of	Education		16a. Dece	dent's Usu	al Occupa	ation	workina	16b. K	(ind of Business/	
vithin ne.	e Me	mpl	Elementary/Secondary (0-12)	College (1-4or 5	5+)				during most of ')				
filed v Hygie	nt, it	e Co	12 17. Father's Name (First, Middle, La	st)		Auto	Mecha	nic	18 Mother's	Name (First, Middi		tomobile	2
d be ental	C BV6	To Be	Calvin Richie							Salley Fu			
should and Men	umat	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ing Address	S (Street a		r Rural Route Num			ip Code)
and 2 salth a salth a n 27 le	er tra		Barbara A. Rich	ie/ Wife						eet Seabr	ook,	MD 2070)6
D - 1 9	or oth		20a. Method of Disposition 1 Burial 2 XCremation 3	☐Removal from State	20b. F	Place of Disposemetery, crea	osition (Nai matory or o	me of other plac	θ)	Date	20c. L	ocation - City or	Town, State
rmit. Pages partment of portant: If it	njury		* 4 □ Donation 5 □ Other (Spec	cify)	Hu	ntt Cr				/13/2005		dorf, M	
parti. Departr	any ir		21. Signature of Funeral Service (c	ensee						Robert E. Road Bowi			al Home
			23a. Part1. Enter the disease, or co	mplications that caused	the deat							20713	Approximate
Physi	cian		shock, or heart failure. List on Immediate Cause (Final disease or condition	me cause on each in	T	Tati	P	axc	11.00	10 07	Oc	eng	Interval Between Onset and Death
/Med	lical		resulting in death)	a. Due to (or as	a conseq	uence of):		,	2010	6		2/20	6 month
Exam	iner	_	Sequentially list conditions,	b. Car	C.1	nom	2 6	1/_	UV,	nary	Bl	deler	18 years
peq	rsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a conseq	uence of):		U					
execu	al-tra	Exar	that initiated events resulting in death) Last	c. Due to (or as	a conseq	uence of):							
te be ex	the burial-transit	ical		d									
rtifica no ph	as th		IF FEMALE:										
ath ce	or use	lan/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 □ Live birth	2 Feta	I déath 3	⊒Ectopic p					23d. Date of deli	very Day Year
he de	peq:	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Uлknowл	4□Pregna <i>n</i> t at 9□Unknown	time of d	leath 5[Other (sp	pecify)				WOITH	Day Teal
that t	should be detached for use as t		Part II. Other significant conditions	contributing to death b	ut not res	ulting in the u	indertying d	ause give	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
quires n sign	old be	ed by								1 🗓	es 2	□No 3□Pro	bably 4 □Unknown
aw re	2 should	Completed								24a. Wa			topsy findings available
The I	page	Com								per 1 Yes	opsy formed? 2 No	death?	ompletion of cause of 2 No
reician: The law	actor,	Be (25. Was case referred to medical examiner?		-					Death (Check only			
Physic this c	al dire	To	1 Yes 2 No	Hospital:		ER/Outpatier			4 Nursii	ng Home 5 ☐ Res			ify)
ding F.	funeral director, page	tlon	27. Manner of Death 1	28a. Date of Inju (Month, Da)	ry y Year)	28b. Time o Injury	of 2	28c. Injury Work	rat ⟨? /es 2 □ No	28d. Describe	how inju	ry occurred	
Atten deat	by the	fica	3 Suicide 6 Could not	be 28e. Place of Inju	ury - At h	ome, farm, st			2	28f. Location	(Street ar	nd Number or Ru	ral Route Number,
s afte	ad in t	Certification;	4 Homicide	building, etc	c. (Specif	(y)				City or To	own, State	9)	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: Attent its certificate has been stoned by the attending physician and	completely filled in		29a. Certifier 1 ☐ Certifying I	Physicien: To the best eminer: On the basis of	t examına	wledge, deat	th occurred	at the tim	e, date and p	lace, and due to the	e cause(s)) and mariner as	stated.
the P	mplete	Medical	one) 29b. Signature and title of certifier	and manner sta	ated.			c. License		occured at the time			
T w T	8		250. Signature and time of certifier	2 - 1	, ,	me 1	-	-	000	9	_	te signed (Month	
			30. Name and address of person wh	o completed cause of d	leath (Iten	n 23a) (Type	Print)	- /		-		11210	()
	_		T. CHANC,	HIEN	88	24	Cu.	nni	nghi	Can IV.	Be	rugh t	teight.
S. B.	Sta egistr		31. Date filed (Month, Day, Year)	nns 32 Registra	ar's Signa	ature			0				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2005 Adella July 17, Statte 3:50 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Larkin Chase Nursing Center Bowie Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, March 13, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M ZIXIXE **Director** 179-10-5842 96 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location in than "natural", or Items 23a or 28a-f show the Madical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes XX No Directo Maryland Prince George's Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 309 Aragona Drive 20744 USA filed within 72 hours after death the Hygiene. Step the their than "natural", or Items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 □ Yes 21\times\text{No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ŽŒ No þ 3€XWidowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Shoe Packer Packing 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fill.
Department of Health and Mental Hy
Important: If item 27 is marked oth
any injury or other traumatic event
2008. 17. Father's Name (First, Middle, Last) Be Joseph DeFrank Roslyn Imbrognio ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edmund B. Madden - Son-in-Law 6209 Edward Drive Clinton, Maryland 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ARemoval from State Harrisburg, Pennsylvania Holy Cross Cemetery July 22, 2005 *4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 21. Signature of uneral Service-Licensee 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part. Enter the disease, or complications that call shock, or heart failure. List only one cause on e sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PIRATOR Pnysician ONE DAY /Medical Due to (or as a consequence of) Examiner DYCPHAGI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed ADVANCE resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 KNo 9 Unknown 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by UNDER 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? **¾**√ No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death. Check onl. one Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2XXNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 3 DOA After thi 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? 1 XXIatural 5 Pending investigation Nithin 24 hours after death.
To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Typa, Print) & Road, # 220, AO NO 31. Date filed (Month, Day, Year)

JUL 2 0 2005 32. Registrar's Signatur State CLASE Registra

			riease					. Ensure Ai Health and M	•	-	ble.	
			1 - State	State of IV	iai yiai ii		tificate of			~ ~	0 =	25100
		п	Registrar 1. Decedent's Name (First, Middle, Las	st)		- 061	incate of	Dealit	2. Date of Deat	eg. Nø.	10	3. Time of Death
	Physicia		Thomas Curtis S	ager					Month July 1	Day	Year	6:15 p M
	. /Medic Examin		4a. Facility Name (If not institution, give		r)		4b. City, Town, o	or Location of Death	July 1	4c. County		
			Coffman Nursing	Home			Hagers	town		Was	hingt	on
	Funeral		5. Social Security Number 6. S	9x 7. A		ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)		lace (State or Foreign
	Director		220-10-3569 Usual Residence of Decedent	25 2		89 Yrs.			Dec. 24	,1915		yĺand
land	Mo T		10a. State 10b. County		10c. City	, Town or Lo	cation				1	0d. Inside City Limits
Man	e de la	tor	Maryland Washingt	ton	Has	gersto	พา					1 ☐ Yes 2√∑No
th the	or 284	irec	10e. Street and Number				10f. Zip Code		1	0g. Citizen of	What Cour	ntry?
E K	ems 23a or 28a-f show armant be notified at	rai	18822 Preston Roa	ad			21742	2		USA		
1215-0036 with the Maryland	ltems Define	Funeral Director	11. Marital Status	12. Was Deceden Armed Forces	?	S. 13. V	Vas Decedent of H	Hispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Rad Bla	ce - Americ	an Indian, etc.
0036 hours aft	io iii	y F	1 ☐ Never Married 2 [3] Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	,	□Yes 212 No	Specify:			y: Whi	
100 P	atura cel E	edt	15. Decedent's Fo	lucation		16a. Deced	lent's Usual Occur	pation		16b. Kind of B	usiness/loc	duetor
21.5 Pin 7	Media 0	plet	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or	.5.\	(Give life. L	kind of work done OO NOT use retired	ation during most of worki d)	ing	TOD. KING OF D	1311622/11C	Justiy
	er th	Completed by	12	4	3+)	Owner	-Operato	or		Lumbe	r Con	npany
	d other	Be (17. Father's Name (First, Middle, Last)					18. Mother's Name				
aryla should	E Ka	٩	Louis Aaron Sag						Middlek			
- 3 E N	f Health and Mitem 27 is mari		19a. Informant's Name/Relationship (1		and Number or Rura				/
e, N	Health em 27 ther tr		20a. Method of Disposition		20b. Pt	ace of Dispos	Z Prestor	n Road, Ha		n, Md.		
MS mor	0		1 ☑ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify		9		sition (Name of natory or other place	ı				
Saltimore	Department Important: I any injury o		21. Signature of Funeral Service Licen		Kes			ery 7/22/				Maryland
~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	Impo any ii		> S. Marke Si	72		10000						Md. 21742
/	9 10		23a. Part1. Enter the disease, or companies shock, or heart failure. List only	olis one cause	d the death	. Do not ente	er the mode of dyin	ng, such as cardiac o	or respiratory arre	st,	own,	Approximate
Phy	ysician		Immediate Cause (Final disease or condition	one cause on each	mon	MIMI	6)				<	Interval Between Onset and Death
///	/ledical		resulting in death)	a Dualty or a	s a consequ	ence of):	On	4_				unis
EX	aminer	L	Sequentially list conditions.	b. 1000	wew	ec's	Du	enty			7/	Opens
1 8	Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	s a consequ	ience of)	100 400	Hom. 6		Dec. 0		conten 0
жеси	sician and burial-transit	хап	that initiated events resulting in death) Last	Due to (or as	s a consequ	ence of):	grina	maur	700	me	1	gears
760, Is be executed	sicia bur	calE				•			V			
	2. C			. U								
tun to Mysi Li Records, P.O. Box 68 The law requires that the death oertifica	endin r use	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pregnancy			23d. Da	te of delive	ry
B. B	he att	sicle	in the past 12 months? 1 Yes 2 No	4□Pregnant a			Other (specify)	<i>'</i>		Мо	nth	Day Year
P.O. at the	ed by the detached	Phy	9 Unknown									
ds,	signe signe	by	Part II. Other significant conditions of	ontributing to death	Dut not resu	iting in the un	iderlying cause giv	en in Part I.				e cause of death?
Orc	been s	Completed							-	s 2 No	3 Proba	
$\mathcal{M}\mathcal{M}\mathcal{M}$ (ital Recordian: The taw requ	has je 2	mpi							24a. Was ar autopsy perform		Were autop prior to com death?	osy findings available npletion of cause of
	certificate ha	e Co	25. Was case referred to peoical						1 ☐ Yes 2	No 1	Yes	2 No
₹ > 50	s certific	0 8	examiner?	Hospital:	ient 2 🗆 E	ER/Outpatient	3□ DOA Oth	er: 4 Zerveine Her	Theck only one The 5 ☐ Resider			
		1	27. Manner eath	28a. Date of Inj (Month, Da	urv	28b. Time of	28c. Injun	y at 2	28d. Describe ho)
(41) E Ivision or Attending	ctor: Aft y the fun	atio	1 ☐ atural 5 ☐ Pending 2 ☐ Accident investigation		ay rear)	Injury	M 1	K? Yes 2 □ No				
Ud Me Division Lor Attending	Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of in	ijury - At hor	me, farm, stre	et, factory, office	4	28f. Location (Str. City or Town,	eet and Numb State)	er or Rural	Route Number,
Sital o	urs an	Ce										
Hos	Fune Fune	edical	29a. Certifier 1 Certifying Ph. (Check only one) 2 Medical Exam	liner: On the basis of	of examinati	vledge, death on and/or inv	occurred at the tin estigation, in my o	ne, date and place, a pinion, death occurre	and due to the ca ed at the time, da	use(s) and ma te and place, a	nner as sta and due to	ated. the cause(s)
o the	within 24 hours after of To the Funeral Direc completely filled in by	Mec	29b. Signature and title of certifier	and manner s	iaieū.		29c. License			d. Date signed		
	> = 0		> Strauel (han)			1)26	655		chy)	0.)	005
			30. Name and address of person who	completed cause of	death (Item	2 3 a) (Type, F	Print)	.1		10.	1 -	(()
41-10	7.5		324 EAST An	Tietom	Street	4. Suc	2 2 0	; HAgen	HOWN, I	n_0	17/9	LO .
	Star Registra		31. Date/filed (Month, Day, Year)	005 32. Project	rar's Signati	H. de	elle	, . ,	,			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July Hyson Smith 19, 2005 3:29 aM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10710 Heather Glen Way Prince Georges Bowie 7. Age (In yrs. last birthday) 9 2_{Yrs.} | House 1 Year | Hours | Min. | 8. Date of Birth | North | Days | Hours | Min. | 0 6 - 0 8 - 1 9 1 3 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Wash. DC **Funeral** 1 M 2 XF 579-66-2933 Director Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City, Town or Location item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, to a Madical Examinar must be notified at 10d. Inside City Limits PG MD Bowie Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 10710 Heather Glen Way 20720 USA death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 💆 No Black Specify: Specify: 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7/ h and Mental Hygiene." 7 is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) Lab Technician Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Hyson Pearl Grigsby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, is 1 and 2 s of Health an Harold Smith/ Son 3444 Newport Ave., Annapolis, MD 21403 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages I Department of H Important: If ite any Injury or ot M☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial 7-23-05 Suitland, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licenses 22. Name and Address of Facility Taylor's Funeral Home 1722 N. Capitol St. NW Washington DC 2000 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician Weeks Lung Cancer disease or condition resulting in death) Primary /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed anding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death in the past 12 months? 3 Ectopic pregnancy jo Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 the a 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 99 1 ☐ Yes 2 ➡ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? certificate Division of Vital 1 Yes 1 ☐ Yes 2 ☐ No 2 XNo Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 AResidence 6 Other (Specify) ပို 1 ☐ Yes 2 🛣 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA SIL 28a. Date of Injury (Month, Day Year) After the funeral 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide within 24 hours all To the Funeral D completely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the ٥ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 20, 2005 D26331 unacens HM 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marta Anne Scheider 5401 McArthur Blvd. NW Washington DC 20016 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2005 Registrar

			For	State of Maryla	•			Mental Hy	giene	
			1 - State Registrar		Cei	tificate of	Death		Reg. No.	251.01
2	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day Yee	G. Time of Death
	/Medic	al			helton		1 1 1 1 1	July	17 200	
	Examin	er	4a. Fecility Name (If not institution, give s	1 1 1 2	+1-	0	Location of Death		4c. County of De	MORE
	Funeral		5. Social Security Number 6. Sex	10spital Cen	rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir		
	Director		266 15 3188 18	M 2□F 5		Months Days	Hours Min.	(Month Da	25 1954	Birthplace (State or Foreign Country)
	Pu ,		Usual Residence of Decedent							
	shov	2	10a. State 10b. County		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	Director	mo CARR	UZZ	FINA	SRURG-		———	40-02:	
	with Be or	ă	2877 Balti	mone Rlus	^	210	8 PC		10g. Citizen of What	A
	ns 23	by Funeral		12. Was Decedent Ever in	n U.S. 13. \	Was Decedent of H	lispanic Origin? (S	pecify Yes or No		merican Indian,
ဖ	or item	五	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No		f Yes, specify Cuba	an, Mexican, Puert	o Rican, etc.)	Black, W	hite, etc.
03	rat',		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 € No	Specify:		Specify:	white
21215-0036	within 72 hours after death with the Maryland ene. then *naturat', or items 23e or 28e-1 show he Madical Exeminer must be routiled at	Completed	15. Decedent's Educ (Specify only highest grade		(Give	lent's Usual Occup kind of work done	during most of wor	king	16b. Kind of Busines	
12	withir Bne. then	шc	Elementary/Secondary (0-12)	College (1-4or 5+)		OONOT use retired ANAGE	*		HARVEST PAR	
	filed Hygid other	CO	17. Father's Name (First, Middle, Last)		///	7177716		ne (First, Middle,	RESTAU	CITIVI
an	id be ental ked o	To Be	WAYNE SI	HELTON			BETT		ANDOLPI	4
Maryland	shou and M a mar umat	-	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailin	g Address (Street	and Number or Ru	ral Route Numbe	er, City or Town, State	, Zip Code)
	and 2 ealth a n 27 to		KaTIHLEEN She	ItON/WIFE	287	7 Baltim	one Blue	FINI	SBURG-n	10 21048
ore	of He of He fiten		20a. Method of Disposition 1 ☐ Burial 2 【■ Cremation 3 ☐ Re	208	b. Place of Dispo	sition (Name of	. 1	Date	20c. Location - City	or Town, State
Ĕ	Pages ment of ant: If it		4 □ Donation 5 □ Other (Specify)	S	DUTH CA	nnoll Cre	m 7/18	5/2005	WINFIEL	o, mo
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturat", or items 23e or 28e-1 show any figury or other traumatic event, the Madical Exoninar must be rediffed at ODGE.		21. Signature of Euneral Service License						wn Fit dr	
	707 e 0		Mary N. Sin	morun				-11	THE PROPERTY AND ADDRESS OF THE PARTY OF THE	MO 21784
			23a. P. M. Adle the disease, or o mplic shock, or heart failure. List only on	e cause on each line.	eath. Do not ent	er the mode of dyin	ig, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
à	Physician / /Medical	8 14	Immediate Cause (Final disease or condition resulting in death)	Anoxic	enceph.	alopath	Y			
	Examiner			Due to (or as a cons	0	Laillat.	1			
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons		brillatio	217			
	outed Id ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Probable o	orona	ry arter	ry dise	ease		
o,	e exe ian ar urial-t	Ex	resulting in death) Last	Due to (or as a cons	sequence of):		1			
8760,	cate be executed physician and the burial-transit	dlcai	0				·			
9	death certific a attending p		IF FEMALE:	3c. If yes, outcome of pre-	anana.					
Bo	atten for us	clan	in the past 12 months?	1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of d Month	elivery Day Year
o.	the d	iysic	1 Urknown	9□ Unknown	31 064(1) 31_	Other (Specify)				
Division of Vital Records, P.O. Box	s that	by Physiclan/Me	Part II. Other significent conditions con	tributing to death but not	resulting in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use contribute	to the cause of death?
rds	quire on sig uld b	ed b	Nicotine depende	ence				1 🗗	Yes 2□No 3□.	Probably 4 Unknown
000	aw re	plet	Hypertension / L	Depression				24a. Was		autopsy findings available completion of cause of
m m	The ate has page	Completed	2/11	Indraid obe	situ			autop perfo 1 Yes	rmed death'	es 2 No
/ita	cian: ertific actor,	Be (25. Was case referred to medical	,	3.17		26. Place of Dea	th (Check only o	one)	
) 	Physic this c	2	1 ☐ Yes 2 ŴNo		ER/Outpatien		4 Nursing H		dence 6 □Other (Sp	pecify)
UC.	Jing F	lon	27. Manper of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c. Injun Worl	yat k? Yes 2 □No	28d. Describe f	now injury occurred	
18	deatl deatl ctor: y the	fical	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - A	t home, farm, stre		163 2 110	28f. Location /5	Street and Number or	Sural Soute Number.
<u>S</u>	after after Dire	Certification:	4 Homicide determined	building, etc. (Spe	ecify)	ou, lastery, emoc		City or Tox		,
	hours hours unera y fille		29a. Certifier 1 Certifying Phys	ician: To the best of my l	knowledge, death	occurred at the time	ne, date and place,	and due to the	cause(s) and manner	as stated.
	To the Hospitat or Attending Physician: The law requires that the death certify within 24 hours attendenth. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	ledical	one)	er: On the basis of exam and manner stated.	unation and/or inv	estigation, in my o	pinion, death occui	red at the time,	date and place, and d	ue to the cause(s)
	To T To 1	Σ	29b. Signature and title of certifier	\cap		29c. License			29d. Date signed (Mo.	
•	NIL		▶ G Boston M	~		0.28	,		1	2005
	7		30. Name and address of person who con	noleted cause of death (I Northwest	tem 23a) (Туре. Носрі	tal Cent	er Ran	Hoad	un Mar	yland 21133
	Sta	to	31. Date filed (Month, Day, Year)	32. Regigtrar's Sig		TENT COIL	OI NOIT	OW HOTE		114113 11103
	Registr				. 16	land.				

			For State Registrar		ryland / Depa <i>Ce</i>		of Health of Death		•	giene Reg. No 20	05	25405
	Physic	ian	1. Decedent's Name (First, Middle, Last		T GERTRU	DE CC	LIA NID DT	מביט	2. Date of De Month	Day	Year	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, give		I GERIKU		WILL OCATION		JULY	16, 20	05	1:10 P ^M
1	Exami		141 LIBERTY ST				STMINS				ROLL	
	Funeral		5. Social Security Number 6. Se	7. Age	(In yrs. last birthday)	If Under 1 Y		r 24 Hrs. Min.	8. Date of Bir (Month, Da			ce (State or Foreign
	Director		Usual Residence of Decedent	3.0. 2631	94 Yrs.				11/10	/1910		LAND
	ryland how		10a. State 10b. County		10c. City, Town or Lo	cation					100	d. Inside City Limits
	Ba-fs	cto	MD CARROLI		WESTMIN	ISTER						1 □ Yes 2 No
	with the	Dire	10e. Street and Number			10f. Zip Co	ode			10g. Citizen of	What Country	y?
	Jeath ms 23	Funeral Director	141 LIBERTY ST		rer in U.S. 13.1		157	rining /Co.	anife Man as No	USA		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or flems 23e or 28e-f show other traumatic event, the Madical Exprimer rust be natified at	þ	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		f Yes, specify			ecify Yes or No Rican, etc.)	Specify	ce - American ck, White, etc	c.
5-0	72 hc natur	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece	dent's Usual O	ccupation one during mos	st of worki	na l	16b. Kind of B		
121	within ane. than	dm	Elementary/Secondary (0-12)	College (1-4or 5+)	lite I	DO NOT use re	etired)		,,,g			
102	illed Hygid othar ant, II	Be Co	17. Father's Name (First, Middle, Last)			НС	DUSEWI 18. Moth		(First, Middle	HOME I		
/lar	should be filed ind Mental Hygi s markad othar umatic evant, I	To B	BAR	TON TAYLO	OR			RGAR		HATT(,	
Maryland	2 sho and is ma	ľ	19a. Informant's Name/Relationship (Ty	DON	19b. Mailir	g Address (St	reet and Numb	er or Rura	l Route Numbe	er, City or Town,	State, Zip Co	ode)
	is 1 and of Health itam 27 other tr		RICHARD J. SCHA		20h Place of Dieno	cition (Alama a	.6			CER, MI		
Baltimore,	0 0		1 ☐ Burial 2 ☐ Cremation 3 ☐ P ☐ 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State T.	cemetery, cren	atory or other	place)	7/10	/ n 5	20c. Location - BALTIM		
altir	그 돈 뿐 글		21. Signature of Funeral Service Livense		22	. Name and Ad	ddress of Facili	/ I J .		FUNER		
m	Depa Impo any ir		M Lang /hrs	holale	25	4 E.	MAIN S	л. Т. 7. Т	WESTMI	NSTER,	MD.	мв 21157
The state of the s	Pnysician /Medical Examiner	ner	23a. Part1. Enter the disease of complishock, or hearfailure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. (Disease or injury	Due to (or as a c	consequence of):	er the mode of	dying, such as A Her	cardiac o	Feu	rest, H	In	pproximate terval Between nset and Death
68760,	the death certificate be executed y the attending physician and iched for use as the burial-transit	ledical Examine	resulting in death) Last	Due to (or as a c	onsequence of):	9						
P.O. Box	that the death certific ed by the attending p detached for use as	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown	8c. If yes, outcome of the street of the st	Fetal death 3 ne of death 5	Ectopic pregna Other (specify	"			23d. Dati Mor	e of delivery nth Da	y Year
	The law requires that ate has been signed b page 2 should be deta	ò	Part II. Other significant conditions con	tributing to death but n	not psulting in the un	derlying cause	given in Part I.		23e. Did to	bacco use contr		eause of death? y 4 □Unknown
		e Completed	25. Was case referred to medical				26 Place	of Death	24a. Was a autops perform 1 Yes :	med? d	rior to comple leath?	findings available etion of cause of
)	S S	ToB	examiner? 1 ☐ Yes 2 No		2 ER/Outpatient	3□ DOA	OH			ence 6 🗆 Othe	or (Specify)	
o u	ding P h. After t funera	on:	27. Manner of Death 12Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	28c. Ir	njury at Work?			w injury occurre		
isio	l or Attandl after death. Diractor: A	cat	2 Accident investigation 3 Suicide 6 Could not be	Ope Diese of Jaiway	A4 5 6 1		Yes 2 1					
<u>≥</u>	or A	l Certification;	4 Homicide determined	building, etc. (5					City or Towr	· ·		
	To the Hospital within 24 hours a To tha Funaral is completely filled	edical	29a. Certifier (Check only one) Certifying Physical Examin	cian: To the best of mar: On the basis of example and manner stated	amination and/or inve	occurred at the estigation, in m	e time, date and ry opinion, deat	d place, ai h occurre	nd due to the ca d at the time, da	ause(s) and mar ate and place, a	nner as stated nd due to the	d. e cause(s)
	To th withir To th comp		29b. Signature and title of certifier			29c. Lice	ense number		2:	9d. Date signed	(Month, Day	, Year)
	152		asumas	2 mg		D	D517	05	t	7-18	- 200	5
	N-6		30. Name and address of person who cor	349 18	alwim.	DR,	Hes	tmi	nstaz	9d. Date signed 07-18 	211	57
:8	State Registra	ar	31. Date filed (Month, Day, Year) JUL 1 9 2	32. Resistrar's	Signature	books						

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No.) 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Robert Floyd Saylor July 2005 14 1835 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**□**M 2□ F Months Director 237-54-3840 68 April 03 1937 Tenn Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b County 10a State show traumatic avant, the Medical Exarcher threat be notified at Sykesville 1 ☐ Yes 2√2 No MD Carroll Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or Itams 23a 3201 Sykesville Road 21157 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1√2 Yes 2 □ No 17 Yes, Give 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: by Specify: White 3 Widowed 4 Divorced "natural" Year or Dates: leted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 or Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natt any injury or other traumatic avant, the Montewalt. 16b. Kind of Business/Industry Social Security Compl Elementary/Secondary (0-12) College (1-4or 5+) Communication Specialist 12 Administration 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Saylor Anna Ford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pok Sun Saylor/wife 3201 Sykesville Road Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 7/19/2005 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Meadow Branch Cemetery Westminster, MD 22. Name and Address of Facility Pritts Funeral Home and Chapel, P.A. 21. Signature of Funeral Service Licensee 412 Washington Road Westminster, MD 21157 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final VENTRICULAR FIBRILLATION Physician Instani disease or condition resulting in death) /Medical Cardiovasaulardisease Phoresdonatic Examiner eau Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. | 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ pe q 2 1 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has t autopsy this certificate 2 1 No 1 ☐ Yes Division of Vital Hospital or Attending Physician: al director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 SER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Diractor: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide hours after To the Hospital of within 24 hours at To the Funeral D completely filled in 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D18 200 7-14-05 WIL 100-Aprole Pd. was minuter FID 21157 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 MAGANNAMD 2HITTUACHED 4 31. Date filed (Month, Day, Year) lever & specie 1 8 2005 Registrar

		1 - For Stata Registrar	State of	Marylan	•	artment of <i>tificate o</i>			-	giene Reg. No.		
Physic /Medi		1. Decedent's Name (First, Middle, Las LILLIE E •	SHOW	ELL					2. Date of De Month JULY	16, 2	.005	9 тто прав
Exami		4a. Facility Name (If not institution, give PENINSULA REGIONA			ER	4b. City, Town		of Death			ounty of Death	
₁ Funeral Director		216-56-2382	x □M 2 X)F	. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Ye Months Day	ar If Under	24 Hrs. Min.	8. Date of Bir Month, Da JAN 4,	1952	9. Birthp Cour MAR	place (State or Foreign http:) YLAND
Aaryland f ehow	ō	Usual Residence of Decedent 10a. State 10b. County DEL ALIA DE CHICCEN		10c. City	, Town or Lo						1	0d. Inside City Limits 1 X Yes 2 ☐ No
with the A 3a or 28a-	i Direct	DELAWARE SUSSEX 10e. Street and Number 68 HONOLULU ROAD			FRANK	10f. Zip Code	945			10g. Citize	en of What Cour	ntry?
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other then "natural", or Iteme 23e or 28e-f show other treumatic event, the Madical Examinar must be notified at	Completed by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deced Armed Forc 1 Yes 2 If Yes, Give Year or Dat	es? !⊠No	'	Was Decedent of f Yes, specify C		gin? (Spe n, Puerto I	cify Yes or No Rican, etc.)		Black, White,	etc.
iled within 72 hours affiliations. Hygiene. Hygiene. Other then "natural; or ent, the Madical Exam	ompieted	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4	4or 5+)	(Give life. l	tent's Usual Oct kind of work do DO NOT use ret CTION L	ne during mos ired)		ng		of Business/In	•
Maryland: d 2 should be filed th and Mental Hyg it is marked othe treumatic event,	To Be C	17. Father's Name (First, Middle, Last) CHARLES E • SHO	WELL				18. Mothe		(First, Middle NN MI'	, Maiden Si TCHEL		
re, Mar s 1 and 2 sho f Health and item 27 is m other treum		19a. Informant's Name/Relationship (7 SHERRILL D. STURO 20a. Method of Disposition	SIS / DA	20b. P	68 H	-	ROAD,	FRAN		DELA	Town, State, Zip $WARE \ \ 19^o$ ation - City or To	945
Baltimore, Mi permit. Pages 1 and 2 Depertment of Health a importent: if Item 27 is eny injury or other tre once.		1 🕅 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen:)	ate	RTIS CI	EMETERY Name and Ad ATSON FI			/2005	BISHO	OPVILLE,	, MARYLAND
auth certificate be executed be executed by W. W. W. W. W. W. W. W. W. W. W. W. W.	edicai Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or	r as a consequer as a	uence(of):	er the mode of o	fying, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
that the death certified by the attending detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown		th 2 Fetal nt at time of de	death 3	Ectopic pregna Other <i>(specify)</i>				23	d. Date of delive Month	ery Day Year
w requires that been signed b should be deta	þ	Part II. Dther significant conditions of	ntributing to dea	ith but not resu	ulting in the u	nderlying cause	given in Part I			obacco use Yes 2	,	ne cause of death? pably 4 □Unknown
The law requires to take the second of the s	Completed								24a. Was auto perfo 1 Yes		prior to co death?	psy findings available mpletion of cause of 2 No
Physician: The Physician: The Physician The Physician The Physician The Physician Phys	To Be	25. Was case referred to medical examiner? ↑ Yes 2 □ No	Hospital: 1 □ Ing	nationt 2K	ER/Outpatier	t 3 DOA	Other		(Check only one		□Other (Specif	iv)
Attending ar death. ector: Afte by the fune	Certification: T	27. Manner of Death 1	28a. Date of Month.	Injury Day Year)	28b. Time of Injury	28c. lr	njury at Vork? □ Yes 212	No 2	28d Describe	how injury	Number or Rura	rehide
To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	Medicai (29a. Certifier (Check only one) (Check only one)	vsicien: To the b inar: On the bas and manne	is of examinat	wledge, deatl tion and/or in	occurred at the restigation, in m	time, date an y opinion, dea	id place, a th occurre	and due to the ed at the time,	cause(s) a date and p	nd manner as s lace, and due to	tated. the cause(s)
To ti withi To ti	W	29b. Signature and title of certifier	onica	-Poll	dens	0	.C.M.E			JULY	signed <i>(Month,</i> 20	Day, Year))05
ET 6	ate	30. Name and address of person who of the company of the company (Month, Day, Year)	wich-Pall	of death (Item	PENN S'	Print) PREET, I	BALTIMO	RE,M	ARYLANI	2120	01	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** R13 9 M Irvin Hewitt Samis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner bryand General tomore of Birth 8. Date (Mon If Under 24 Hrs. Social Security Number (In yrs. last birthday) 9. Birthplace (State or Foreign Age Year] 1919 **Funeral** Country) Maryland 1**₽** M 2□ F Months Days Hours 218-05-0828 86 April Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County item 27 la marked other than "natural", or items 23s or 28a-f show other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 236 € 68 Summer Hill Park 21032 United States by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married If Yes, Give Year or Dates: WWII 1 Yes 2 No Specify: Specify: white Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Encyclopedias 18. Mother's Name (First, Middle, Maiden Sumame, 17 Father's Name (First, Middle, Last) Be should be fi John Elsworth Foxwell Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other training. 901 Second St. Pocomoke City, MD 21851 Brian Samis/ son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages nent of h 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-20-05 Davidsonville, MD Lakemont Mem. Gardens 21. Signature of Funeral Service License 22. Name and Address of Facility John M. Taylor Funeral Home, Inc 147 Duke of Gloucester St. Annapolis, MD 21401 complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each lige. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or com shock, or heart failure. List only Meumonia Immediate Cause (Final **Physician** on disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ion with Rapid Vertricular Response burial-transit certificate be executed Box 68760, physician Physician/Medicai use as the attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 hnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Z No Hospital: 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA the funeral 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Division or Attending 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide within 24 hours a To the Funeral E Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely To the 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 29c. License number

Registrar
DHMH 17 Rev 1/2001

State

Name and address of person who completed cause of death (Item 23a) (Type,

31. Date filed (Month, Day, Year)

Physic	ian_	1 - State Registrar 1. Decedent's Name (First, Middle, Last	•	Certifica	ate of Death		Reg. N2 0 0 5	25409 3. Time of Death
/Medi Examir	cal	Mildred Eliz 4a. Facility Name (If not institution, give North Arundel	street and number) Hospital	4b. Ci	y, Town, or Location o Glen Bu	Death Irnie	4c. County of Dea	Arundel
rector		Usual Residence of Decedent	□M 2 X F 89	Yrs. Month	ler 1 Year If Under 2 s Days Hours	Min. 8. Date of Birth (Month, Day Sep. 20	9. Bir 7, 1915	nthplace (State or Foreign ountry) MD
28e-f shov	ector	MD 10b. County Anne Ar 10e. Street and Number			verna Park		10- 6::	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
23e or	ai Di	442 Riverdale Roa	ad	101. 2	21146		10g. Citizen of What Co USA	ountry?
r then "neturel", or items 23e or 28e-f show the Modical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, sp	edent of Hispanic Orig pecify Cuban, Mexican, 2 X No Specify:	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame Black, White Specify:	erican Indian, te, etc. White
r then "netur I're Modical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	completed)		val Occupation rork done during most use retired) ecords Lib		16b. Kind of Business Crownsvil Hospit	le State
marked other umetic event, I	To Be C	17. Father's Name (First, Middle, Last) Edward Franklin B			18. Mother	's Name (First, Middle, I ry Snyder	Maiden Sumame)	
tre T		19a. Informant's Name/Relationship (Ty Catherine E. Jone	s/Daughter	8108 Ma	in Creek D	ror Rural Route Number rive, Pasad	; City or Town, State, 2 ena, MD 2	Zip Code) 1122
Importent: If Item 2 any injury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)	Removal from State Ced	ace of Disposition (N metery, crematory or ar Hill Ce	ame of other place) emetery	July 18, 2005	20c. Location - City or Brooklyn,	
any in		21. Signature on Juneral Service Licens	160	Barra 495 G	nco & Sons ov. Ritchi	, P.A. Seve e Hwy, Seve	rna Park F rna Park, 1	uneral Home MD 21146
chosician and the printing strains the printing str	dicai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence). Due to (or as a consequence). Due to (or as a consequence).	ence of):	Cicad	LENT		
ed by the attending pridetached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnand 1□Live birth 2□Fetal of 4□Pregnant at time of dea 9□Unknown	death 3 □Ectopic (23d. Date of deli Month	ivery Day Year
pe a	by	Part II. Other significant conditions con	stributing to death but not result	ting in the underlying	cause given in Part I.	23e. Did tob	acco use contribute to	
2 2	Completed					24a. Was ar autopsy perform	prior to c death?	topsy findings available completion of cause of
in di	ertification: To Be	27. Manner of S ath 1 Platural 5 Pending investigation 3 Suicide 6 Could not be		Injury M	OA Other: 4 Nurs 28c. Injury at Work? 1 Yes 2 No		nce 6 Other (Spec	
oy the funer		4 Homicide	building, etc. (Specify)			City or Town,	State)	
ely filled in by the fun	0	29a. Certifier Check only (Check only Medical Examin	ician: To the best of my knowler: On the basis of examination	edge, death occurred	at the time, date and	place, and due to the cal	use(s) and manner as	stated.
pletely filled in	ledical C	29a. Certifier (Check only one) 29b. Signature and title of certifier	ician: To the best of my knowler: On the basis of examinatio and manner stated.	Transcor investigation	I at the time, date and n, in my opinion, death	occurred at the time, da	te and place, and due	to the cause(s)

				epartment of Health and Mer	ntal Hygiene	E 05110
	Physici		1. Decedent's Name (First, Middle, Last) John Ludwig Sarkissian		Date of Death Month Day Ye	9. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	July 11, 20	
			931 Edgewood Road Apt 214	Annapolis	Anne	Arunde1
	Funeral Director		5. Social Security Number 348-12-9743 Usual Residence of Decedent 6. Sex 1 M 2 F 82 Y1	Months Days Hours Min.	Date of Birth (Month, Day, Year) 9. [uly 22, 1922]	Birthplace (State or Foreign Country) Illinois
	yland		10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
	Mar 6-f st	ctor	Maryland Anne Arundel	Annapolis		1 X Yes 2 □ No
	or 28	Dire	10e. Street and Number	10f. Zip Code	10g. Citizen of Wha	t Country?
	ath w	rail	931 Edgewood Road Apt 214	21403	United St	ates
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 te marked other then "naturel", or Items 23s or 28e-f show any injury or other traumatic event, If a Mudical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in US Amed Forces? 1942 1 Never Married 2 Married 1946 13. Was Decedent Ever in US Amed Forces? 1944	 Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ric 1 ☐ Yes 2 X No Specify: 	y Yes or No- an, etc.) 14. Race - A Black, V Specify:	American Indian, Vhite, etc. White
21215-0036	ithin 72 holes.	Completed	15. Decedent's Education (Specify only highest grade completed) (6. (6. (7. (1.4 or 5+) 16a. (1.4 or 5+) 16a. (1.4 or 5+) 16a. (1.4 or 5+)	Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Busine	ess/Industry
2	led wi lygien her th	Con	5+	Professor	Teach	ing
Maryland	12 should be filed within h and Mental Hygiene. 7 le marked other then "traumatic event, pre Med	Be	17. Father's Name (First, Middle, Last)		irst, Middle, Maiden Sumame)	
2	should id Mei marke matic	ပ	Elisha Sarkissian 19a. Informant's Name/Relationship (Type, Print) 19b. N	Araxie Sha Mailing Address (Street and Number or Rural Re		to Tip Code)
	and 2 s ealth ar n 27 le				ater, Maryland	
re,	item item othe		20a. Method of Disposition 20b. Place of Disposition	Disposition (Name of Crematory or other place)		
Ĕ	Pages nent of I ent: If its ury or o		I Dunai 2 Macientation 3 Linemovalitoni State I .	re Crematory 7/12/2	005 Baltimore	, Maryland
Baltimore,	permit. Departr Importe any injv		21. Signature of Funeral Service Licenside	22. Name and Address of Facility John 147 Duke of Gloucest		
8760,	cate be executed Wedical Physician and the burial-transit	dicai Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. I any Laung Limited allocause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) C. Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of)	i Infarction	spiratory arrest,	Approximate Interval Between Onset and Peath MINUTES
P.O. Box 6	ath certifi ittending or use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of Month	delivery Day Year
	luires that the de n signed by the a lid be detached f	d by Pl	Part II. Other significant conditions contributing to death but not resulting in the acrtic stenosis	ne underlying cause given in Part I.	23e. Did tobacco use contribute 1 √ es 2 □ No 3 □	e to the cause of death?
Ö	aw require s been sig	olete	hypertension		24a. Was an 24b. Were	autopsy findings available
X.	The lavate has	om			autopsy prior death	
ıta	sicien: The l certificate ha rector, page	Bec	nyperlipidemia 25. Was case referred to medical examiner?	26. Place of Death (Cl	heck only one)	
Division of Vital Records,	nys i di	on: To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa 27. Manner of Death 1 Natural 5 Pending 2 Accident Accident Accident Provided Injury 1 No Accident Investigation (Month, Day Year) 1 Inpatient 2 ER/Outpa 28a. Date of Injury (Month, Day Year) 1 Inpatient 2 ER/Outpa 28b. Time Injury (Month, Day Year)	ne of 28c, Injury at 28d.	5 ☐ Residence 6 ☐ Other (S Describe how injury occurred	(pecify)
DIVIS	tel or Attending Pi s after death. el Director: After ti ed in by the funera	Certificati	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office 28f.	Location (Street and Number or City or Town, State)	Rural Route Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dependent on the basis of examination and/or and manner stated.	leath occurred at the time, date and place, and or investigation, in my opinion, death occurred a	due to the cause(s) and manner t the time, date and place, and c	as stated. due to the cause(s)
	Vith To	Σ	29b. Signature and title of certifier	29c. License number D 4 7 3 1 1	29d. Date signed (Mo	
		-	// Nococa		07/12	107
			30. Name and address of person who completed cause of death (Item 23a) (Ty 5. Niemela, MD. 205 Ridgely QU	e. annapolis, MD 2	1401	
	Sta Registra	-	31. Date filed (Month, Day, Year) JUL 1 4 2005 32. Recorrar's Signature	Souls		

			1 - For State Registrar		laryland / De _l				ne	5 25611
	Physic	ian	Decedent's Name (First, Middle, Last	,	m 13			Date of Death Month	Day Yes 27 200	3. Time of Death
	/Medi Exami		Helen Albert 4a. Facility Name (If not institution, give		Todd	Ab City Tourn	or Location of Death	July 2		11103021
	Exami	iei	304 South Fou			Bel Ai			4c. County of D	
	Funeral		Social Security Number 6. S	9x 7. Ag	ge (In yrs. last birthda		If Under 24 Hrs.	8. Date of Birth	9.1	Birthplace (State or Foreign Country)
L	Director		246-22-1747 Usual Residence of Decedent	□M 2 以 F	98 Yrs.	Months Days	Tiours Willi.	(Month, Day, Ye 04/25/1	907 N	orth Carolina
	laryland ehow		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	e-fet	ctor	MD Harfo	cd	Bel Air					1 ☐ Yes 2 🔯 No
	be filed within 72 hours after death with the Maryland that Hygiene. Identify then "netural", or Items 23a or 28e-f ehow of other than "netural", or Items 23a or 28e-f ehow ovent, the Marical Exerting must be retified at	Funeral Director	10e. Street and Number 304 South Fou	ntain Gree	en Road	10f. Zip Code 210	15	10g.	Citizen of What	
	tems	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	Was Decedent of I	Hispanic Origin? (Spe can, Mexican, Puerto	ecify Yes or No-	14. Race - Ar Black, W	merican Indian,
36	rs afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 If Yes, Give		1 ☐ Yes 2 🖾 No		insuit, oto.)	Specify: _	
Maryland 21215-0036	2 hour	ted t	15. Decedent's Ed	Year or Dates: ucation	16a, Dec	edent's Usual Occu	pation	16h	. Kind of Busines	hite
215	within 73 ene. than "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5	(Giv	re kind of work done DO NOT use retire	during most of worki	ng	. Kind of Busines	ss/maustry
2	filed with Hygiene. other than	Con	7	0		Homemake	r		Home	
and	outd be fil Mentat H arked ott atic even	Be	17. Father's Name (First, Middle, Last)					(First, Middle, Maid	,	
Ž	shoutd ind Men imarke	2	Byrd Lundy 19a. Informant's Name/Relationship (7	vne Print)	10h Mai	ling Address (Strans		Edwards		
	01 00 00 00		Dr. Cynthia L. Le				and Number or Rura			
ore,	of Health of Health item 27		20a. Method of Disposition		20b. Place of Disg		- D		Location - City	
Ë	Pages ment of I ent: If its ury or o		ty Burial 2 ☐ Cremation 3 ☐ ' 4 ☐ Donation 5 ☐ Other (Specify			Mem. Gdns		′05 B∈	el Air,	Maryland
Baltimore,	permit. Pages Department of I Importent: If its any injury or or		21. Signature of Funeral Service Licen:	Zellm		22. Name and Addre	ess of Facility	12188¶€33§	₉ A.	-
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or colors shock, or heart failure. List only of limediate Cause (Final disease or condition resulting in death)	aDue to (or as	a consequence of):	heart	<u></u>	r respiratory arrest,		Approximate Interval Between Onset and Death
8760,	icate be executed physician and s the buriat-transit	dical Examiner	Sequentially list conditions, if any leading to the diale cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):	narch				syears
.O. Box 6	The law requires that the death certific te has been signed by the attending p page 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy	y		23d. Date of d	elivery Day Year
S, D	signed to	by P	Part II. Other significant conditions co		ut not resulting in the	underlying cause giv	ren in Part I.	23e. Did tobacco	use contribute	to the cause of death?
ord	w require been sig should b	ted	Parkinsons	Viscase				1 🗆 Yes	ZZNo 3□F	robably 4 Unknown
		Completed	Tick sine sy	ndrone				24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
<u> </u>	siclen certifi rector	Be	25. Was case referred to medical examiner?	lospital:		Oth	26. Place of Death			
Division of	Attending Physicien: or death. ector: After this certific. by the funeral director.	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	1 ☐ Inpatie 28a. Date of Injur (Month, Day	ry 28b. Time o	of 28c. Injur Wor	4 Nursing Hom	e 5 esidence 8d. Describe how inj		əcify)
Divisi	tal or Attending Is after death. al Director: After ed in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	ury - At home, farm, st c. (Specify)			Bf. Location (Street a City or Town, Sta	and Number or F te)	lural Route Number,
·	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) 1 ✓ Certifying Phy 2 ☐ Medical Exami	sician: To the best on ner: On the basis of and manner sta	of my knowledge, dea examination and/or in ited.	th occurred at the tin	ne, date and place, ar pinion, death occurre	nd due to the cause(d at the time, date ar	s) and manner and place, and du	s stated. e to the cause(s)
	with To	Σ	29b. Signature and title of certifier	h.00	MO	29c. Licens			ate signed (Mon	
			publiar () meet	111	0000	48050	F	- /27/0	5
	10		30. Name and address of person who co	mpleted cause of de	S. Parkes	Print) # 40	48050 Abed cer	MO 711	201	
	Sta	te	31. Date filed (Month, Day, Year)	32. Seristra	ar's Signature	1	70000	1 10 611		_
	Registra		AUG 0 3 20	05 Males	w B. A	and a				

				epartment of Health and Certificate of Death		ene 005	25412
	Physici /Medi		Decedent's Name (First, Middle, Last) Ewing Hows Tavel		2. Date of Death Month July	Day Year	3. Time of Death
	Examir		4a. Facility Name (If not institution, give street and number) Holy Cross Rehab. & Nursing Center	4b. City, Town, or Location of De		4c. County of Des	ath
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 579-10-0564 12 F 89 Yr Usual Residence of Decedent	day) If Under 1 Year If Under 24 H	8. Date of Birth (Month, Day, June 8,		omery hthplace (State or Foreign ountry) nnessee
	e Maryland Ba-f show tiffed at	ctor	10a. State 10b. County 10c. City, Town of	or Location er Spring			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with th	Director	10e. Street and Number 209 Baden Street	10f. Zip Code 20901	10	g. Citizen of What Co	ountry?
036	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-f show Ita Mudical Examiner mast be notified at	by Funeral		13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 ☐ Yes 2 ☑ No Specify:	(Specify Yes or No- lerto Rican, etc.)	USA 14. Race - Ame Black, Whit	te, etc.
21215-0036	hin 72 ho a. an *natur	Completed	(Specify only highest grade completed) (6	Decedent's Usual Occupation Give kind of work done during most of vite. DO NOT use retired)	working 10	6b. Kind of Business	/Industry
nd 21	e filed wit al Hygiene I other the vent, Il e	Be Con		stems Accountant 18. Mother's N	De Name (First, Middle, Ma	epartment of	the Army
Maryland	hould b d Ment marked matic e	Tof	Ewing Hows Tavel 19a. Informant's Name/Relationship (Type. Print) 19b. N		Caroline		7.0
Baltimore, Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28e-f show any intry or other treumatic event, If a Medical Examiner outsibe notified at once.		Jean W. Tavel/ Wife 200 20a. Method of Disposition 20b. Place of Disp	Mailing Address (Street and Number or D) Baden Street Single Single Single Street Single Street Single Street Single Street Single Street Single Street Single Street Single Street Single Street Street Single Single Sin	lver Sprin	g. Marylar Oc. Location - City or	nd 20901 Town, State
Balti	permit. Departm Importe any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Francis J. Collin 500 University Bl	s Funeral	Home Inc	ng, Maryland
	Physician	e p	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Aspiration Pneum resulting in death)	t enter the mode of dying, such as card	liac or respiratory arres	t,	Approximate Interval Between Onset and Death 4 Days
68760,	physician and burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of)	estinal Bleed :			4 Days
O. Box (at the death certificaby the attending place by the attending place is an indicate and the control of the contr	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ⊟Ectopic pregnancy 5 □ Other (specify)		23d. Date of deli Month	ivery Day Year
rds, P	as this		Part II. Other significant conditions contributing to death but not resulting in the Coronary Artery Disease, Hypertension, Dema			cco use contribute to	the cause of death?
Vital Records,		Completed by			24a. Was an autopsy performe 1 □ Yes 2 ∑	prior to death?	Itopsy findings available completion of cause of 2 No
o	ding Phys h. After this funeral di	ertification: To Be	27. Manner of Death 1 Datatural 5 Pending (Month, Day Year) Inju 2 Accident investigation	atient 3 DOA Other: 4 X Nursing	eath (Check only one) Home 5 Thesidence 28d. Describe how		cify)
	o pir	Certific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	Iral Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, d Medical Exeminer: On the basis of examination and/o and manner stated.	eath occurred at the time, date and placer investigation, in my opinion, death occurred.	ce, and due to the caus curred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
11		Σ	29b. Signature and title of certifier Multiple Action (M.)	29c. License number D57630		Date signed (Month	
			30. Name and address of person who completed cause of death (Item 23a) (Ty Anuradha Arun, M.D. 10301 Georgia	pe,Print) Avenue, #209, Sil	Tron Consti	MD 0000	•
	Sta Registra		31. Date filed (Month, Day, Year) JUL 2 0 2005 Registrar's Signature	rate	ver spring	, MD 2090	2

				State of Ma	rvland	/ Departm	ent of H	lealth	and Mer	ntal Hynie	ne	
			1 = For State Registrar	Otato of Mic	ii y tarra		cate of				. No.2 A A E	* ***
			Decedent's Name (First, Middle, La	st)	. /					Date of Death	No.Z U U	9:-Time of Death
п	Physici		Francic		TI	como	SOL	1		Month OT	Day S Year	15 1550
	/Medic Examin		4a, Facility Name (If not institution, give	re street and number)			City, Town, o	r Location			4c. County of Dec	ath
			Constal Hosa	sice at t	ho L	ate S	Palis	bu	ry		Wic	omico
	Funeral				(In yrs. las	Mon	nder 1 Year oths Days	If Under		Date of Birth (Month, Day, Y		rthplace (State or Foreign country)
L	Director		143–14–1149	XW 201 5	51	Yrs.			0	6-19-	-1424 Ne	w Jersey
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Location	1					10d. Inside City Limits
	Mary feho	ō	Maryland Wicomi	co	All	len						1 ☐ Yes 2 No
	1 the	Director	10e. Street and Number				f. Zip Code			10g	. Citizen of What C	Country?
	ours after death with the Marylan el', or Items 23a or 28e-f e how Exantrer must be notified at		3284 Allen Road				21810)			USA	
	ems a	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was D	ecedent of H	fispanic Or	rigin? (Specify an, Puerto Ric	y Yes or No-	14. Race - Am Black, Wh	
36	or It	y Fu	1 Never Married 2 Married	1 XYes 2 N		100	es 22 No	Specify		u., o.,	Specify: W	
21215-0036	d within 72 hours after death with the Maryland glene. sr than "naturel", or Items 23a or 28e-f ehow tre Madical Essainar nast te netitied at	d by	3 Widowed 4 Divorced	Year or Dates: [Marine					F		
쟌	n 72	Completed	15. Decedent's E (Specify only highest gr	de completed)		16a. Decedent's (Give kind of life. DO NO	of work done of OT use retired	durina mos	st of working	16	b. Kind of Busines	3/Industry
12	within iene. ' than "	mo	Elementary/Secondary (0-12)	College (1-4or 5	+)	Inspec		-,			Can Comp	any
b	景を発す	Be C	17. Father's Name (First, Middle, Last)				18. Moth	er's Name (F	irst, Middle, Ma		
a		To B	Francis Joseph T	nompson Sr.				Euc	genia E	3ock		
Maryland	d 2 should th and Mer 7 Is marke treumatic		19a. Informant's Name/Relationship	**							City or Town, State,	Zip Code)
	and and mast mast		Wilma Thompson/w	ife 		PO Box	•	•				
Baltimore,	ite it		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	20b. Plac	ce of Disposition netery, crematory	(Name of or other place	ce)	Date	20	c. Location - City o	r Town, State
Ë	tment tent:		* 4 □ Donation 5 □ Other (Special	5/)	Alle	en Cemete		į	7/20/0		Allen, MD	
Baj	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Lice	PS90	2000	HOL.	le and Addres	ss of Facil Funer	al Hom	ne Profe	essional	Association
	46200		23a. Part1. Enter the disease, or com	owey (the death		SHOW	UTTT	RO., S	allsbur	Y, MUZI	804 Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	e. , ,	0	mode of dyin	ig, such as	s cardiac or re	sspiratory arrest	•	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. 110765	TIL	Ren	L_	Ca	rein	0114		a months
8	Examiner		- 1	Due to (or as a	a conseque	nce or):						0 % 2001
		er	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	conseque	nce of):						
	outed id ansit	Examiner	Cause (Disease or injury that initiated events	С.								
ó	be executed sicien and burial-transit		resulting in death) Last	Due to (or as a	conseque	nce of):						
8760	\$ × 0	Ical		_ d.								1
9	leath certifica attending ph	Med	IF FEMALE:									
Вох	ath catternation us	ian/	23b. Was decedent pregnant	23c. If yes, outcome of	2 Fetal d	eath 3 Ectop	oic pregnancy	/			23d. Date of de Month	elivery Day Year
o	the a	Physician/M	in the past 12 months? 1 ☐ Yes No 9 ☐ Unknown	4☐ Pregnant at 9☐ Unknown	time of dea	th 5 ☐ Othe	r (specify)					-,
٦.	that the de led by the a		Part II. Other significant conditions	contributing to death bu	ıt not resulti	ng in the underly	ing cause give	en in Part	L.	23e. Did tobac	co use contribute	to the cause of death?
Vital Records,	uires signe	d by								1 🗆 Yes	2No 3□F	robably 4 🗆 Unknown
00	w requir been si should	ompleted								24a. Was an	24b. Were a	utopsy findings available
Re	0 - 0	mo								autopsy performe	prior to death?	completion of cause of
ta	sicien: Th certificate rector, pag	e C	25. Was case referred to medical					26. Place	e of Death (C	1 ☐ Yes 2X Theck only one)	No 1 □ Ye	s 2170
	S S D	To B	examiner? 1 🗆 Yes 2 2 No	Hospital:	nt 2 EF	NOutpatient 3	DOA Oth	00			e 6 Other (Spe	əcify)
n of	ding Ph h. After thi funeral		27. Manner of leath Natural 5 Pending	28a. Date of Injur (Month, Day	y Year) 2	8b. Time of Injury	28c. Injun Worl			. Describe how		
<u>S</u>		catic	2 Accident investigation			M		Yes 2]No			
Division	for Atten after deat Director:	Certification:	3 Suicide 6 Could not be determined		ry - At hom . (Specify)	e, farm, street, fa	ctory, office		28f.	Location (Street City or Town, S	et and Number or F State)	lural Route Number,
	Hospitel (Hospitel (Hours al Funerel D tely filled i	ပိ	20- Cadilian Discontinuo									
	To the Hospitel or within 24 hours after To the Funerel Dire completely filled in b.	edical	29a. Certifier (Check only one) Certifying Pl	ysician: To the best on miner: On the basis of and manner sta	examinatio	n and/or investiga	rred at the tin ation, in my o	ne, date ar pinion, dea	nd place, and ath occurred a	at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	11/11			29c. License	e number		29d	Date signed (Mon	th, Day, Year)
}	-0		1) (C	41	N	10	1	26	278		7- 7	F-000
	5 IM		30. Name and address of person who	completed cause of de	ath (Item 2	3a) (Type, Print)	0 1		0 / 8		1-20	. 03
	IVH		DAVID CALALL, MI	O COATA	L 4	3a) (Type, Print)	POL	Dx/	733	Selve	Le Ki	- OS D 31802
•	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signatur	L 1	. 10	7-17-)/	
	Registr	ar	JUL 2 1	COO3	W J	or Apa						

			1 - For Stete Registrar	State	of Marylar			t of H	ealth a		ental Hy		0.05	25616
	Physici	an	Decedent's Name (First, Middle Biak	, Last) To							2. Date of De July 1	ath	5 Year	3. Time of Death 2:30am M
	/Medic Examir		4a. Facility Name (If not institution Kline Hospice	give street and n	umber)				Location of	of Death	July 1	4c. Cou	inty of Death Freder	1
	Funeral Director		5. Social Security Number 586–45–8955	6. Sex 1 □ M 2 □ F	7. Age (In yrs. 5		If Under Months		If Under:		8. Date of Bir April			nplace (State or Foreign untry)
	aryland show	'n	Usual Residence of Decedent 10a. State 10b. County		10c. Cr	ty, Town or Lo	cation							10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	or 28a-f	Directo	Maryland Frede 10e. Street and Number	erick		<u>Freder</u>	ick 10f. Zip	Code				10g. Citizen	of What Cor	
036	be filed within 72 hours after death with the Maryland ital Hyglene. id other than "natural", or items 23s or 28s-f show event, the Medical Exp. in ethical Le netition at	by Funeral Director	91 Blueridge Cou 11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was De Armed I	2⊠No Bive						cify Yes or No Rican, etc.)		Race - Amei Black, White	
21215-0036	within 72 hor ene. than "natura fre Modical E	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	t grade completed	(1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us itary	rk done d se retired,	luring mosi)	t of workin	ng		of Business/I	•
Maryland 2	should be filed to desire that the single marked other to matic event, to	To Be Co	17. Father's Name (First, Middle, Lal Hnin	Last)	4	PILL.	LLary	OII	18. Mothe	er's Name Thl	(First, Middle		ese A1	ılıy
	alth ar 27 Is r trau			nip (Type, Print) Lfe	1	91 B	luerio	dge	Ct. F	rede	Route Numb	MD 217	03	
Baltimore,	r tree		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)	pecify)	II State	Place of Dispo cemetery, crer sthaven	Mem.	Gard	lens	Ju1y 20	005	Freder		Maryland
Bal	permit. Departm Importa any inju		21. Signature of Fineral Sanice	5/		9.	501_Ca	atoc	tin M	[tn.]				
	Physician /Medical Examiner	her	23a. Part. Enter the disease, or shock or heart value. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Act	each line. Ite Subd O (or as a consec	ural He			g, such as			rederi	ic of	Approximate Interval Between Onset and Death 8 days
68760,	ficate be executed physician and is the burial-transit	edicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	o (or as a consec	quence of):			C	إسلا	17 0 0 11 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2) Etalli		
P.O. Box	that the death certifica led by the attending ph detached for use as th	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	utcome of pregn birth 2 Feta gnant at time of c mown	al déath 3 🛭	Ectopic pro		A	A ST	STEA - WE	23d.	Date of deli Month	very Day Year
	law requires that as been signed I 2 should be det	by	Part II. Other significant condition: Hypertension ;	_	_	_		_						the cause of death? bbably 4 Munknown
Il Records,	The ate h	Completed									24a. Was auto perfo 1 \(\text{Yes} \)		tb. Were aut prior to c death? 1 \sum Yes	topsy findings available ompletion of cause of
f Vita	Physician: Th r this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 □ No	Hospital: 1 [Inpatient 2	ER/Outpatier	nt 3□ DO	Othe			(Check only one 5 ☐ Resi		Other (Spec	ify) Hospice
Division of Vital	Attending Ph ir death. ector: After th by the funeral	on:	27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	Jul Jul	e of Injury onth, Day Year) 9, 2005	28b. Time or Injury 1115	р ^м	8c. Injury Work	at :? ∕es 2) [⊡		8d. Describe Fe11 v			ng steps
Divis	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certificati	3 ☐ Suicide 6 ☐ Could I 4 ☐ Homicide determ	ined 288. Pla	ce of Injury - At h ding, etc. <i>(Speci</i> At home	fy)		<u> </u>			Fred	wn, State) 9 erick,	1 Blue Maryl	
	n 24 hou n 24 hou ne Fune pletely fil	edical	29a. Certifier 1 Certifyin (Check only 2 Medical one)	g Physicien: To t Exeminer: On the and ma	he best of my kno basis of examina inner stated.	owledge, deat ation and/or in	n occurred a vestigation,	at the tim , in my op	e, date an pinion, dea	d place, a th occurre	nd due to the d at the time,	date and pla	I manner as ce, and due	stated. to the cause(s)
)	To the within To the comp	X	29b. Signature and title of certifier	7			29c	License DOO	number 4 7 951			29d. Date sig	18, 2	
-	ì		30. Name and address of person Sibte A. Kazm.				-				, Mary			
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)		Registrar's Sign									

Rico Vazquez 05-04756 NJM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

,	.1		1- State Registre Amended item	State of Ma as 20b&c p	ryland/ er fh/	Depa Cei	artment of F rtificate of	lealth and Death wi	l Mental Hyg .chd/7–20 n	05/d1s	5 25415
	Physic	an	Decedent's Name (First, Middle, Las	vid					2. Date of Deat Month July	h	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give		Vazque	ez	4b. City, Town, o	r Location of De		14 200 4c. County of D	
-	LAAIIIII		811 Chippewa Bo				Salis		aui	Wicom	
45	Funeral Director		5. Social Security Number 6. Se 192–70–3409	DM 2DC	(In yrs. last i	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		Year) 9. E	Birthplace (State or Foreign Country)
	pu 🔏		Usual Residence of Decedent 10a. State 10b. County		10-00-7				11/30/		Texas
	Aaryla f sho	ō	Maryland Wicomic	<u>,</u>	10c. City, To						10d. fnside City Limits 1 X Yes 2 ☐ No
	the A	Directo	10e. Street and Number		Sali	Lsbur	10f. Zip Code		1/	0g. Citizen of What	
	th with	aiD	811 Chippewa Blv	d.			21801			USA	oountry:
36	2 should be filed within 72 hours after death with the Maryland and Menial Hygiene. Is marked other then "natural", or items 23a or 28s-f show eumatic event, the Macinal Examples Trust be notified at	by Funeral	11. Marital Status 1 Xever Married 2 Married	12. Was Decedent E Armed Forces? 1 Yes 2 XN If Yes, Give		1	Was Decedent of H f Yes, specify Cuba	ispanic Origin? In, Mexican, Pue Specify: Me			
9	tural	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edi	Year or Dates:	16		lent's Usual Occup				Hispanic
Maryland 21215-0036	d within 72 jiene. r then "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)			(Give life. [ient's Osual Occupi kind of work done o DO NOT use retired Iscaper	ation during most of w f)	rorking	Landsca	·
nd	9 = 0 >	Bec	17. Father's Name (First, Middle, Last)				June	18. Mother's N	ame (First, Middle, N		ibrud
yla	should b	일	Jose Vazquez						a Baldero		
Mai	d 2 sh th and 7 is rr treum		19a. Informant's Name/Relationship (T) Greg Tucker/employe		15				Rural Route Number,		
ē,	es 1 and 2 should b of Health and Ment filtem 27 is marked r other treumatic e		20a. Method of Disposition		20b. Place	of Dispos	Sition (Name of	thsdale	Dr., Sali	Sbury ME 20c. Location - City	21801 or Town, State
E C	Pages nent of I ant: If Its ury or o		1 ☐ Burial 2 🖾 Cremation 3 🔼 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Pantio Salis	n lo	sition (Name of natory or other place cal del Cremator	Quelital	1110 9/05		11o. Mexico
Baltimore,	permit. Page Department Important: It eny injury o	<	2. Signature of Funeral Service Aces			22	Holloway	Funera	ıl Home Pr , Salisbu	ofessiona	l Association
3	Physician /Medical Examiner		A3a. Parf 1. Enter the disease, or comp shick, or heart failure. List only of mmediate Cause (Final disease or condition resulting in death)		ct gu	onot ente	the mode of dying	g, such as cardi	ac or respiratory arre	st,	Approximate Interval Between Onset and Death
	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of my y that initiated events resulting in death) Last	b. Due to (or as a c. Due to (or as a							
98760	ficate be physicia s the bur	edical		d							
O. Box	the death certificate be executed to the attending physician and ached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal deat		Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
rds, P	The law requires thet the de te has been signed by the a lage 2 should be detached t	ģ	Part II. Other significant conditions co	ntributing to death but	not resulting	in the un	derlying cause give	on in Part I.			to the cause of death?
Vital Hecords,		Completed							24a. Was an autopsy perform	ed death:	autopsy findings available completion of cause of
ıra	ysiclen: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	1.00				26. Place of De	eath (Check only one		es 2 No
0	Phys this al di	ဥ	1 √ Yes 2 No Path	lospitaf: 1 ☐ Inpatient			3□ DOA Othe	4 Nursing	Home 5 ☐ Resider		ecify) Scene
	ding Ih. After funer	ertification;	1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day	Year) 28b.	Time of Injury	28c. Injury Work	at ? (es 2 🗷 No	28d. Describe how	w injury occurred	
DIVISION	Atten	Ifica	3 Suicide 6 Could not be determined	28e. Place of Injur	y - At home, f	arm, stre		163 2 1/2/140	281. Location (Stre	et and Number or I	Rural Route Number,
5	tel or rs afte al Dir	Cert	4 Homicide	building, etc.	(Specify)	+ h	ame_		City or rown,	State)	elishury, MD
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying Phy (Check only one) Medical Exami	sician: To the best of ner: On the basis of e and manner state	ranimation a	ge, death nd/or inve	occurred at the timestigation, in my op	e, date and plac inion, death occ	a and due to the are		
	with Comp	×	29b. Signature and title of certifier	N			29c. License		29	d. Date signed (Mor	nth, Day, Year)
	S		· Catrinea	コオー			OC	CIE .		July, 15	, 2005
	2		30. Name and address of person who co	14 AC	7	(Type, P	^{'rint)} 111 Per	nn Stree	et Baltim		land 21201
	Sta Registra	_	31. Date filed (Month, Day, Year) JUL 2 0 2	005 32. Refistrar	's Signature	A	parti				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 7:25P M 2005 MARGARET MARY MATTHEWS WOODLAND JULY 15, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CHARLES WALDORF WALDORF HEALTHCARE CENTER If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** 1 ☐ M 2 🖸 F MARYLAND Director 215-36-4385 76 20, 1929 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County an "natural", or items 23a or 28a-f ehow Medical Examiner must be notified at 1X Yes 2 No INDIAN HEAD MARYLAND CHARLES Direct 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number UNITED STATES 103 CHARLES PLACE 20640 death Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examin 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK þ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry **FEDERAL** Elementary/Secondary (0-12) College (1-4or 5+) CAFETERIA WORKER 8th GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY ESTELLE SHELTON MATTHEWS JOHN MATTHEWS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CYNTHIA SIMMONDS / DAUGHTER 9508 PIN OAK STREET CLINTON, MARYLAND 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State *4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 7/21/2005 CLINTON, MARYLAND 22. Name and Address of Facility

THORNTON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee LEON THORNTON 3439 LIVINGSTON ROAD INDIAN HEAD, MD 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a cons squence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 2 No 3 Probably 4 Unknown Completed peeu 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has page 1 Yes 2 No Phyaician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 7 No this f Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Mann f D Certification: After Hospital or Attending 5 Pending investigation 2 No 1 TYes death. 2 Accident after death 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a To the Funeral D 1 👺 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 DOOGIO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael A. Leatherwood, MD 12070 Olde Line Center Waldorf, Maryland 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State JUL 2 0 2005 Registrar

CPM John Malcolm Wrenn Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-04602 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar UNK 05-4602 Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician July JOHN MALCOLM WRENN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Yeoman Place at Old Central Avenue Prince George's Capitol Heights 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min **1X**□M 2□F Director 579-06-3200 26. 1981 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location r 28a-f show WASHINGTON D.C. Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? an "naturel", or Items 23a or Medical Examinar must be 2304 HARTFORD ST., S.E. #201 20020 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BLACK δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th LABORER MAINTENANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) s 1 and 2 should be fi: Health and Mental H tem 27 is marked ott JOHN WRENN KATRINA CARPENTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KATRINA CARPENTER/MOTHER 2304 HARTFORD ST., S.E. #201 Wash., D.C. 20020 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Peges permit. Pages
Depertment of I
Importent: If It
eny injury or or
once. 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FT. LINCOLN CEMETERY 7-16-05 BRENTWOOD, MD 22. Name and Address of Facility CAPITOL MORTUARY INC. 21. Signature of Funeral Service Lice 425 MARYLAND AVE., N.E. WASHINGTON, D.C. 20002 23a. Pant. Enter the disease, or shock, or heart failure. List dications that caused the death. enter one cause on each Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): physicien a s the burial-Physician/Medical attending p 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f ☐Yes 2☐No 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes should 24a. Was an cate has page 2 s autopsy performed? certificate Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Creck only one Be Hospital: 1 ☐ Inpatient 2 txoxYes 2 □ No 2 ER/Outpatient 3 DOA this After thi funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 5 Pending investigation 1 Natural 1 🗌 Yes 2 Accident Director:

Division of Vital Records, P.O. Box 68760,

Certification:

Medical

24b. Were autopsy findings available prior to completion of cause of ath? ath? 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) State) 4 Homicide oldle

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ODA)

29c. License number OCME 29b. Signature nd title of certifier 29d. Date signed (Month, Day, Year) July 09, 2005

who completed cause of death (Item 23a) (Type, Print)

111 Penn Street Baltimore, Maryland 21201

12:26

Birthplace (State or Foreign
Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

3 Probably 4 Unknown

Year

X□Yes 2□No

WASHINGTON.

PM

State Registrar 31. Date filed (Month, Day, Year) 2 0 2005

22. Registrar's Signature

within 24 hours e To the Funerel I

			1 - For State Registrar	State of Marylan		artment of H tificate of L			jiene og. No.	05	25418
	Obveiei		1. Decedent's Name (First, Middle, Last)	-				2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medio		ROBERT S. WES	ST				July 3	2005		2:56 p. M
	Examin		4a. Facility Name (If not institution, give stre			4b. City, Town, or		th		unty of Death	<u>r</u>
			Prince George's Hos	<u> </u>		Cheverly	If Under 24 Hrs			nce Ge	
	Funeral Director		5. Social Security Number 6. Sex 1 № M	2□F 7. Age (In yrs. 6		Months Days	Hours Min		Year)		elace (State or Foreign etry) Carolina
	pu 🛦		Usual Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Lo	agtion					Od. Inside City Limits
	faryla sho	ō	D.C.	100.01	y, 10#1101 CO		shington				Yes 2 No
	the h	Director	10e, Street and Number			10f. Zip Code	or in govern	1	On Citizen	of What Cour	
	3a or		3984 Pennsylvania A	TOTAL CE AND	+ #1Ω°		20020		_	S.A.	,
	ms 2	era		Mas Decedent Cuer in 11		Vas Decedent of Hi f Yes, specify Cubai		Specify Yes or No-	14.	Race - Americ	
ဖွ	or Ite	Fu.	1 Never Married 2 Married	Amond Forces? 1. Yes 2 No If Yes, Give		r Yes, specify Cubai I□ Yes 2 ANo	n, Mexican, Puer Specify:	to Hican, etc.)		Black, White,	
000	72 hours after death with the Maryland netural', or Items 23a or 28a-f show disal Evantrat must be rodified at	d b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		105 22540	Specify.		Spe	ecify: Blac	K
5	"net	lete	15. Decedent's Educat (Specify only highest grade of		(Give	lent's Usual Occupa kind of work done d DO NOT use retired,	uring most of wo	rking	16b. Kind o	of Business/Ind	dustry
12	withli lene. than	Completed by Funeral	Elementary/Secondary (0-12)	College (1-4or 5+)		abbie	,		Cab	Industry	
D	Hilled Hyg other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, i		name)	
Maryland 21215-0036	uld be Aenta rked tic ev	To B	Cl <i>a</i> rence West					Tempie C	ates		
lar	2 sho and h Is ma		19a. Informant's Name/Relationship (Type,			g Address (Street a					
	and ealth m 27		Mrs. Roberta A. West (Wi			Pennsylvan	ia Avenue	-			
ore	ges 1 t of H If itel		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Rem	0	emetery cren	sition (Name of natory or other place ational Cen	entords Tulls			on - City or To	
altimore,	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23a or 28a-1 show any injury or other treumatic event, the Medical Evantment must be retified at once.		' 4 □ Donation 5 □ Other (Specify)	Qu			-1 -	and the second			
Ba	Depa Impo any it		21. Signature of Funeral Service Licensee	James	3	. Name and Addres 339 Hunt PL	-	Rollins Fun Washington			•
			23a. Party. Enter the disease, or complicate cock, or heart failure. List only one of	tions that caused the deat					/	20017	Approximate
	Frysician		Immediate Cause (Final disease or condition		men or	a camp	10-1	1/1/02	Nicas	20-	Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq	uence of):	1-0	10113	200	0.020	134	
ì.	Examiner	_	Sequentially list conditions, b	8							
	ted sit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	neuce offi						
	al-trai	xar	that initiated events c resulting in death) Last	Due to (or as a conseq	uence of):						
68760,	ficate be executed physician and s the burial-transit	edicai E	d								
_	ntificat ng ph) as th	Aedi	ic control								
Вох	death cert e attending id for use	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy			23d.	Date of delive	*
о. П		Physician/M	1 Yes 2 No	4□Pregnant at time of d 9□Unknown	eath 5□	Other (specify)				Month	Day Year
σ.	that the ed by th detache		Part II. Other significant conditions contrib	outing to death but not res	ulting in the ur	iderlying cause give	n in Part I	23e. Did tol	pacco use o	contribute to th	e cause of death?
of Vital Records,	S C O	d by		3	3	,,			s 2□N		ably 4 nknown
00	w require s been sign should b	oiete			-	_		24a. Was a	n 24	b. Were autor	osy findings available
Re	The lav	Completed						autops perform	y ned? 2 ☐ No	death?/	npletion of cause of 2 No
ital	ien: rtiffica ctor, p	Bec	25. Was case referred to medical examiner?				26. Place of De	ath (Check only on			20110
<u>></u>	Physicien: r this certific ral director,	10	1X Yes 2 No Hos	pital: 1 ☐ Inpatrent 2 🔀	ER/Outpatien	3 DOA Othe	1. 4 Nursing H	dome 5 ☐ Reside	ence 6 🗆	Other (Specify)
	ing P	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe ho	w injury oc	curred	
Sio	Attending r death. sctor: After by the fune	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	one Blace of John State			′es 2 □No	006 1		-1	
Division	after of Direct of In by	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif		eet, factory, office		28f. Location (St City or Town		imber or Hurai	Houte Number,
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate hy completely filled in by the funeral director, page		29a. Certifier 1 Certifying Physici (Check only X) Medical Examiner	an: To the best of my kno	wledge, death	occurred at the tim	e, date and place	and due to the ca	ause(s) and	manner as sta	ated.
	To the He within 24 To the Fu	Medical	51107	On the basis of examina and manner stated.	tion and/or inv						
	To To To Com	2	29b. Signature and title of certifier	000	1 4	29c. License OCM		2	gd Pate sig	4 ^{ed} (<i>M2</i> 900)	Qay, Year)
	15		Mulprie Mr	elshill	w	1.	_				
	CAP		30. Name and address of person who comp	A 1/		Print) 111 Peni	n Street	Baltim	ore. I	Marylan	nd 21201
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa					-, -		
	Registr		IIII 2 0 2005 Keep	un Mi dan	who !						

David Wayne Williams 05-RPI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

-04	4964		_ For	State of Marylan	d / Depa	artment of H	lealth and M	ental Hyg	jiene		
D			1 - State Registrar		Ce	rtificate of l	Death	R	leg. No. 🤈 🕦	OC	0511
61	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	Year	3/Time of Dean
	/Medic			<u> </u>	Liams			July 2			0832 A M
	Examin	er	4a. Facility Name (If not institution, give s	treet and number)			Location of Death		4c. County		
		#	Kernan Hospital 5. Social Security Number 6. Sex	7. Age (In yrs.	la et hirthria vi	Baltimor	e If Under 24 Hrs.	9 Date of Birth		timore	
Ь	Funeral Director			M 2□F 35	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Sept.10	Year) 1969	Country Mary1	
	pu ,		Usuel Residence of Decedent	140- 63-	-				, _,,,,		
	shov	'n	10a. State 10b. County		y, Town or Lo					10d.	. Inside City Limits 1 ☐ Yes 2 ■ No
	28a-1	Funeral Directo	Maryland St. Ma 10e. Street and Number	ry's		Tall Ti	mbers		10g. Citizen of W	Ibat Country	
	3e or	ΙΩ	17870 River Shore	Dreitzo			00			,	
	me 2	nera		2. Was Decedent Ever in U.	S. 13.	206 Was Decedent of H	90 Ispanic Origin? (Spe In, Mexican, Puerto F	city Yes or No-	14. Race	ed Sta	Indian,
9	or ite	Fur	1 Never Married 2 Married	Amed Forces? 1 ☐ Yes 2 ■ No If Yes, Give		If Yes, <i>s</i> pecify Cuba 1 ☐ Yes 2 ☑ No		Rican, etc.)		k, White, etc	
8	ural',	d by	3 Widowed 4 Divorced	Year or Dates:		10105 210140	Specify:		Specify:	Whit	e
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Ptyglene. Important: If Item 27 is marked other than "natural", or iteme 23e or 28e-f show any injury or other treumatic event, The Madical Exeminar must be notified at anone.	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of workir	ng	16b. Kind of Bu	siness/Indus	stry
12	withi	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	1		Engineer		Governm	ent C	ontractor
9	illed Hygi other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,			oncractor
lar	uld be Aenta rked tic ev	To B	John W. Williams				Helen Ge	enevieve	Bean		
ary	shor and N		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Maili	ng Address (Street	and Number or Rura			State, Zip Co	ode)
Σ.	and 2 Belth n 27 I		Helen G. Williams		P.O.	Box 195	, Tall Tim	bers, 1	Maryland	2069	0
Baltimore,	Jes 1 of He		20a. Method of Disposition 1 Burial 2 Cremation 3 Re	20b. P	lace of Dispo emetery, crea	sition (Name of matory or other plac	D (28)	ate	20c. Location - (City or Town	, State
Ē	tment tant:		4 □ Donation 5 □ Other (Spenty)	Ho1		Cemetery		-2005	Great M	lills,	Maryland
Bal	Depermine Depermine Important Irreportant		21. Shualut, 1 lineral Service Acense			2. Name and Addres	DLI	nsfield	l Funera	1 Home	e, P.A.
s			Edward N. Brinsfie 23a. Part1. Enter the disease, or complic				ywood Road				0650-0279 pproximate
24			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.						In	terval Between nset and Death
14	Physician /Medical		disease or condition resulting in death)	Oh plu (at)	MS (of Kelme	K Opind	I LOVA.	-thyun	4	
	Examiner			Due to (or as a consequ	uerice or):				9	•	
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):						<u></u>
	cuted nd ransit	Examine	trat initiated events								
Ó,	ate be executed hysicien and the burial-transit		resulting in death) Last	Due to (or as a consequent	uence of):						
8760,	icate be executed physicien and s the burial-transit	Physician/Medical	d								
9	The law requires that the death certific sie hes been signed by the attending page 2 should be detached for use as	Mec	IF FEMALE:	De 16							
Box	attend for us	ian	in the past 12 months?	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do	I death 3	Ectopic pregnancy			23d. Date Mon	of delivery oth Da	ıy Year
o.	that the de ned by the a detached f	ysic	1 Yes 2 No 9 Unknown	9☐ Unknown	ea(ii ə[Other (specify)					
<u>α</u>	res that igned b be deta	by Pt	Part II. Other significant conditions con-	ributing to death but not resi	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contri	ibute to the o	cause of death?
rds	w require: been sig should be							1 🗆 Y	es 2 💢 No	3 🗌 Probabl	ly 4 Unknown
ဝင္တ	law ress bee	Completed						24a. Wasa		Vere autopsy	findings available
æ	The l	mo						autops perfori 1 X Yes	med? de	eath?	letion of cause of
ita	ician: Th certificete rector, pag	Bec	25. Was case referred to medical examiner?				26. Place of Death			92/:03 22	3110
× ×	Physician: r this certific ral director,	Ţ	1 Yes 2 □ No H		ER/Outpatier		4 Livursing Hon	ne 5⊡Reside	ence 6 Othe	or (Specify)	
Division of Vital Records,	ling P	ion:	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work		8d. Describe h	ow injury occurred Pass	en ger	rola.
Sic	Attending r death. octor: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	2/20/05	11:41	PM 10	/\	wot	orvers	clea	ccident
<u>≥</u>	or A efter Direct	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	(Y		2	City or Town	treet and Numbe n, State)	244	Southert
	Hospitel 24 hours Funerel tely filled		29a. Certifier 1 Certifying Phys	ician: To the best of my kno	911 Will wiedge, deat	h occurred at the tim	ne, date and place, a	nd due to the c	ause(s) and man	alley	nd .
	To the Hospitel or Attending Physician: within 24 hours effer death. To the Funerel Director: After this certific	Medical	one) ZC Medical Examin	er: On the basis of examina and manner stated.	tion and/or in	vestigation, in my of	pinion, death occurre	d at the time, d	ate and place, a	nd due to the	e cause(s)
	To the within 2 To the complet	ğ	29b. Signature and title of certifier	i		29c. License		2	9d. Date signed	(Month, Day	y, Year)
	500		I wrote H	allan	wd	000	CME .		July 24,	2005	
	8		30. Name and address of person who con	npleted cause of death (Item	1 23a) (Type,	Print) 111 Da	nn Stract	Da1+-	moses 31	1 =	J 01001
_			LITEOL HA	IL ATU M	A	III PE	nn Street	Dalti	more, Ma	aryıan	IQ 21201

State Registrar

31. Date filed (Month, Day, Year) 32. Regis s Signature 3UL 2 6 2005

		1 - For State Reg	e istrar		State o	f Maryla				lealth a		lental Hy	giene,		5	25420
Physi /Med				eph	Woodro		en, Sr.					2. Date of Dea Month July	25,	2005		3. Time of Death $12:10^{-P}$ M
Exam			ty Name (If not institution			mber)				Location of	of Death			County of D		
			19 Whites Security Number	Neck 6. Sex		7. Age (In vrs	. last birthday)		shwoo r 1 Year	od If Under	24 Hrs.	8. Date of Birt		. Mai		ce (State or Foreign
Funera Directo		214-	-52-3834 esidence of Decedent		M 2□F		83 Yrs.	Months	Days	Hours	Min.	July 2,	v. Year)		Countr	land
1215-0036 within 72 hours after deeth with the Maryland ene. than "natural", or itema 23e or 28e-f show than "matural be notified at	ctor	10a. Stat Mary1	e 10b. Count		's		ity, Town or Loushwood									d. Inside City Limits 1 ☐ Yes 2X No
with th	Dire		et and Number		D 1			10f. Zip					•	en of What		,
eeth va 234	era	11. Marit	9 Whites N			edent Ever in	U.S. 13		0618	isnanic Ori	gin? (Sp	ecify Yes or No		ed St		
U36 ors after d ai', or item	by Funeral Directo	101	ar Status Never Married 2⊠ Ma Vidowed 4 □ Divorce	rried	Armed Fo 1 ☐ Yes If Yes, Gi Year or D	orces? 2 📉 No ve		If Yes, spe		Specify:		ecify Yes or No Rican, etc.)		Black, W	hite, et	c.
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural; or itema 23e or 28e-1 show any injury or other traumatic event, the Medical Exertical market notified at	Completed	Eleme	15. Decede (Specify only high ntary/Secondary (0-12)	est grade	cation e completed) College (1-4or 5+)	(Give	DO NOT L	rk done i	during mas	t of work	ing		d of Busine		,
Hygie thert		17. Fathe	8 er's Name (First, Middle	. Last)			Fa	rmer		18. Mothe	er's Name	(First, Middle,		cicult	ure	
Maryland 10 2 should be file 11 b end Mental Hy 27 is marked oth	To Be	Wi1	liam			lathen	405 14 37		(2)	Ros	sett	a	1	Pi		rton
Man d 2 st th end th end 17 ls n traun	1		omant's Name/Relation V Evelyn Wa			۵.						a <i>l Route Numbe</i> nwood , MD			e, Zip C	iode)
Baltimore, Dermit. Pages 1 an Department of Heel mportant: if item 2		20a. Met	hod of Disposition Burial 2 Cremation Donation 5 Other	3 🗆 R	Removal from	20b. State	Place of Disponentery, cre	osition (Na matory or	me of other plac	:e)		Date 29, 2005	20c. Loc	ation - City		n, State
Baltii permit. F Departme importar any injur	- Sucë		atura of Funeral Service			den	-	2. Name a Matti	nd Addres	ss of Facilit Gardin	y ner Fu	neral Ho	me, P.			
Pnysiciai /Medica Examine	al er	Immedia disease resulting	rt1/Enter the disease, ock, or heart failure. Liste Cause (Final or condition in death)	or complist only or	a Due to	or as a conse	equence of):					Can			1	Approximate nterval Between Onset and Death
. Box 68/60, death certificate be executed e attending physicien and of or use as the burial-transit	dical Examine	resulting	rially list conditions, ading to immediate Enter Underlying Disease or injury ated events in death) Last		c	(or as a conse							-			
0	Physician/Me	23b. Wa in t 1 = 9 =	ALE: is decedent pregnant he past 12 months? Yes 2 \(\sigma \) No Unknown	2	1 Live I	itcome of preg birth 2 ☐ Fe nant at time of nown	tal death 3	⊒Ectopic p ⊒ Other (s		,			23	3d. Date of Month		day Year
d de	þ	rait ii. O	ther significant condi	tions cor	ntributing to d	death but not re	esulting in the t	underlying	cause giv	en in Part l			obacco us Yes 2			cause of death?
I Rec The law ete has b page 2 sf	Completed	-										24a. Was autor perfo		prior death	to comp	y findings available pletion of cause of
of Vital F Physician: Th this certificete ral director, pag	Be	25. Was	case referred to medic niner?	-	Jannital:				Oth			(Check only o				
Phy rathis	tlon: To	10.771	Yes 2⊠No ner of Death Natural 5 ☐ Pend Accident inves	1	28a, Date		ER/Outpatie 28b. Time of Injury		28c. Injur Wor	er: 4 □ Nu y at k? Yes 2 □		me 5 Resi			Specify)	
Division al or Attending s efter death. I Director: After id in by the fune	Certification;	3 [] 4 []	Suicide 6 Coul	-	28e. Place build	e of Injury - At ling, etc. (Spec	home, farm, si	reet, factor	y, office			28f. Location (. City or To	Street and wn, State)	Number of	Rural I	Route Number,
DIVI To the Hospital or Al within 24 hours effer or To the Funeral Direct completely filled in by	edical C		heck only 2 Medica	ing Phy al Exami	ner: On the b	e best of my ki basis of examination of examination of examination of examination of examination of the examination of the example of the exa	nowledge, dea nation and/or i	th occurred	at the tin	ne, date ar pinion, dea	nd place, ath occur	and due to the ed at the time,	cause(s) a date and	and manner place, and	r as stat due to t	ted. he cause(s)
To the within 2 To the complet	₩ E		nature and title of certif	ier	11)			e number				signed (M		-
				1	1	12			033	3123			7	-27	-0	5
300			e and address of p						.1 D	1 #2	10 1	Or Erro				0678
	State		onathan D.							1.,#3.	10, 1	rre.	dello	ــــــــــــــــــــــــــــــــــــــ		
Regi			.1111	28	2005	Timber.	nature ,	April 1	U							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible	e.
State of Maryland / Department of Health and Mental Hygiene	F listed

			1- State of Maryland / Department of Health and Certificate of Death	Mental Hygie	2005 2	5421
	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	Time of Death
	/Medic		BERNICE P WILLIAMS	July 1	7, 2005 2	:30A M
7	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat	th	4c. County of Death	
	Funeval		Suburban Hospital Bethesda 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs	8. Date of Birth	Montgomery 9. Birthplace	State or Foreign
	Funeral Director		217-42-2867 1 M 2 F 93 Yrs. Months Days Hours Min	8. Date of Birth (Month, Day, Y Feb26, 19	912 Maryl	and
	yland yland		10a. State 10b. County 10c. City, Town or Location		10d. In	side City Limits
	e Mar Sa-f sl	ctor	GA Fulton Alpharetta		1	ŽYes 2 No
	vith th	Dire	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Country?	
	s 23s	erai	275 Haydens Walk Ct 30022 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (5	Specify Vos or No.	U.S.A.	dian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "neturel", or Items 23a or 28a-f show any following the most standard to	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes, Give Year or Dates: 12. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 Yes, Give Year or Dates:	to Rican, etc.)	Black, White, etc. Specify: Blac	
21215-0036	72 hou	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of wo	ndring 16	b. Kind of Business/Industry	'
21	ithin 7 9e. Ned "r	npie	Elementary/Secondary (0-12) College (1-4or 5+)	iking		
	iled w hygier her th		8th Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Na	me (First, Middle, Ma	Home	
anc	d be findal Head of	Be c	Agne		,	
Maryland	should nd Me mark mark	မ	Maurice Posey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R			9)
	aith a 27 is		Kirk Canady- Son 275 Haydens Walk	Ct Alphai	cetta. GA 3	0022
ore,	of He of He		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20	c. Location - City or Town, S	
Ē	Pag ment ent: h		'4 □Donation 5 □Other (Specify) Bells Chapel Cem 1//		Dickerson,	
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than any joilung appher treumatic event, Item Mones.		21. Skinature of Funeral Service Licensee) 22. Name and Address of Facility S1 246 N. Washington			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	c or respiratory arres	Inter	oximate val Between
	Pnysician		Immediate Cause (Final disease or condition a. Pseudomonas Infections		Onse	et and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):			
	cuted nd ransit	Examiner	that initiated events c.			
oʻ	e exec ian ar urial-tı		resulting in death) Last Due to (or as a consequence of):			
68760,	tificate be executed g physician and as the burial-transit	edicai	d	1		
Вох 6	h certific ending p		IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delivery	
Ö	that the death cert ed by the attendin detached for use	Physician/N	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown		Month Day	Year
S, P.	res that igned b	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	cco use contribute to the cau	se of death?
ord	v require been si should b	ted	Congestive Heart Failure	1 Tes	2⊠No 3☐Probably	4 Unknown
Records,	The lay ate has page 2	Completed		24a. Was an autopsy performe	24b. Were autopsy fir prior to complete death? No 1 □ Yes 2 ☑ 1	on of cause of
Vital	Physicien: this certific ral director,	Be (25. Was case referred to medical argument? 26. Place of De	ath (Check only one)		
of \	shy this	2			ce 6 ☐Other (Specify)	
nc	ding After fune	tion	1 ⊠Natural 5 ☐ Pending (Month, Day Year) Injury Work?	28d. Describe how	injury occurred	
Division	l or Attending after death. Director: Afte I in by the fune	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office		et and Number or Rural Rout	te Number,
D.	i Site	Certification;	4 ☐ Homicide determined building, etc. (Specify)	City or Town,	State)	
	To the Hospitel or Attent within 24 hours after deatt To the Funerel Director: completely filled in by the	edicai (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examiner and the first occurred at the time, date and place 2 Medical Examiner at the first occurred at the time, date and place 2 Medical Examiner at the first occurred at the fi	e, and due to the cau urred at the time, date	se(s) and manner as stated. a and place, and due to the c	ause(s)
	To the within To the comp	Me	29b. Signature and title of certifier 29c. License number	29d	. Date signed (Month, Day,)	Year)
	20		D37891		July 18, 20	05
	h-0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		•	
			A. Rajvanshi, MD 121 Congressional Ln #409 I	Rockville	e, MD 20852	
	Sta Registi		31. Date filed (Month, Day, Year) JUL 2 0 2005 32. Degistrar's Signature			

			For State Registrar	State of Maryland / Dep	partment of Health and ertificate of Death	Mental Hygie	2005 25100
	Q D		Decedent's Name (First, Middle, I	Last)		2. Date of Death	3. Time of Death
	Physici /Medic		LAYTON	WILLIAMS		07	7 2005 / M
	Examin	er	4a. Facility Name (If not institution, g		4b. City, Town, or Location of Deat SALISBURY		4c. County of Death
	Funeral			e By The LAKE Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs	8. Date of Birth	00,000
	Director		215-38-2408	1 M 2 F 62 Yrs.	Months Days Hours Min.	(Month, Day, Ye	-42 DE
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
	Maryl -f sho fied a	tor	Mr Dilly	Danies Fruit	1 1		1 Yes 2 □ No
	th the or 28e	Director	10e. Street and Number	WILLICO I I	10f. Zip Code		Citizen of What Country?
	ath wi	rai	422 dgle	are	21862		1,5,A
	ltems rer	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
920	hours after death with the Maryland turel', or Items 23e or 28e-f show at Exerciter must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 ☑ No If Yes, Give Y Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Black
21215-0036	72 hours "neturel", dical Ext	Completed	15. Decedent's (Specify only highest	grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of wo	rking 16b	. Kind of Business/Industry
121	d within 72 ho jiene. r than "netu	idmo	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)	B	giley's Tax
	Hyg Hyg ent,	Be Co	17. Father's Name (First, Middle, La	ist) .		me (First, Middle, Maid	
/lar	ould be Mental arked o	To B	Willie Wi	Ilians	Floss	Sie A.W	'Illians
Maryland	2 sho and is m		19a. Informant's Name/Relationship	o (Type, Print) 19b. Ma	iling Address (Street and Number or Ri		
	1 an Heali em 2 ther		Patriga Williams 20a. Method of Disposition	ins - Wife 1.0	BOX21 Eden	M 2 18	Location - City or Town, State
Baltimore,	8 = 5		1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	Hemoval from State	rematory or other place)	125/05 1	blace o
alti	permit. Pag Department Importent: I any injury o		21. Sign nur of Funeral Service Lic		22. Name and Address of Facility	Bennie	smith TH
	20129		Moule	~ Krinds 19	17 W. Isabelle	st-Sali	sbury me 21501
			shock, or heart failure. List or Immediate Cause (Final	omplications that caused the death. Do not entry one cause on each line	enter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between Onset and Death
}	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence of):	2 (0/01)	ana	020 WO.7/11
L	Examiner		Sequentially list conditions	b			
	be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			
	al-tran	Examine	that initiated events resulting in death) Last	c			
8760	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai E		d			
9	ing ph	a)	IF FEMALE:				
Вох	eath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?		B Ectopic pregnancy		23d. Date of delivery Month Day Year
0	at the de by the a tached	ysic	1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of death 9□ Unknown	5 Other (specify)		
S, D	es that igned b	by Pi	Part II. Other significant condition	s contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
ord	w require been si should b				-	1 Tes	2 No 3 Probably 4 Unknown
Records,	elawi hasb	Completed				24a. Was an autopsy performer	24b. Were autopsy findings available prior to completion of cause of death?
Vital F		e Co	25. Was case referred to medical			1 ☐ Yes 2 ☐	No 1 Yes 21 No
	Si Si	O B	examiner?	Hospital: Nnpatient 2 ER/Outpat	Other	ath (Check only one) Home 5 ☐ Residence	e 6 ☐Other (Specify)
n of		on: T	27. Manner of Death Natural 5 Pending	28a. Date of Injury 28b. Time (Month, Day Year) Injury	of 28c. Injury at	28d. Describe how i	
Division	eat or:	icati	2 Accident investigat 3 Suicide 6 Could no	t be	M 1 Yes 2 No	29f Location (Street	t and Number or Rural Route Number,
Di<	i te	Certification;	4 Homicide determin	building, etc. (Specify)	street, factory, office	City or Town, S.	tate)
	To the Hospital or within 24 hours afte To the Funerel Director completely filled in the Funerel Director completely filled in the Funerel Director Completely filled in the Funerel Completely filled		29a. Certifier Certifying	Physicien: To the best of my knowledge, de caminer: On the basis of examination and/or	ath occurred at the time, date and place	e, and due to the cause	e(s) and manner as stated.
	thin 24 the F the F mplete	Medical	29b. Signature and title of centifier				
	£ ₹ 5 8	(1005	O(AM)	12127	8	7-18-05
			30. Name and address of person wi	no completed cause of leath (Item 23a) (Typ	e, Print)		
			DAVID CORAL	LIMD COASTAL HO	FIRE GO.BOXI.	733 Jel.	16 MD 2180-
:	Sta Regista		31. Date filed (Month, Day, Year) JUL 2	0 2005 Elecus B	Sparle		Date signed (Month, Day, Year) 7 - 18 - 05

	1	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2005 251. 2
Physician /Medica Examiner	n il :	1. Decedent's Name (First, Middle, Last) MARY CATHERINE WILLIAMS 2. Date of Death Month Day Year July 17 2005 8:14 PM 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4c. County of Death
Funeral Director		Wicomico Nursing Home $ \begin{array}{c ccccccccccccccccccccccccccccccccccc$
		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD WICOMICO MARDELA SPRINGS 1□Yes 3□No.
ath with the Mar 23a or 28a-f st ust be notified	rai Direc	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11200 SCHOOLHOUSE ROAD 21837 USA
5-0036 72 hours after death with the Maryland natural; or items 23a or 28a-f show dical Exant retinust be notified at	^	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed .4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 17. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 18. Race - American Indian, Black, White, etc. 19. Specify: WHITE
	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER 16b. Kind of Business/Industry OWN HOME
Maryland 212: A 2 should be filed within the and Mental Hygiene. 77 is marked other than traumatic event, the Mary To Bo Company.	To Be C	17. Father's Name (First, Middle, Last) GEORGE B. JONES 18. Mother's Name (First, Middle, Maiden Sumame) CATHERINE BIGGS
ore, Mai ges 1 and 2 sh t of Health and if Item 27 is in or other traum		19a. Informant's Name/Relationship (Type, Print) DANIEL WILLIAMS - SPOUSE 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11200 SCHOOLHOUSE ROAD, MARDELA SPRINGS, MD. 21837 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
Baltimore, M. Baltimore, M. Departiment of Health and Department of Health any injury or other tra		SPRINGHILL MEM. GDNS. 07-20-2005 HEBRON, MARYLAND 21. Gignature Funeral Service Licensee 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804
Pnysician /Medical		23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):
wate be executed any sician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underwin. Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):
Vision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed actor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit director.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 3 Ectopic pregnancy Month Day Year 1 Year
cords, P wrequires that been signed b should be deti	ted by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Yunknown
Vital Reccitician: The law recordificate has be rector, page 2 sh	e Completed by	ACZHEIMERS DISEASE 24a. Was an autopsy performed? PARKINSONS DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 1 yes 2 No 25. Was case referred to medical
Division of Vital Records, To the Hospital or Attending Physician: The law requires the within 24 hours after death. To the Funeral Director: After this certificate has been signed pempletely filled in by the funeral director, page 2 should be or the funeral director.	ToB	examiner? 1 Yes 2x No
Divisio To the Hospital or Attends within 24 hours after death. To the Funeral Director: A gompletely filled in by the to	Certification:	2 Accident investigation 3 Suicide 4 Homicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
the Hospital thin 24 hours a otha Funeral ompletely filled	Medical	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
To Troil		Multiplier \mathcal{T} T
State Registra	e	Mahesha Thimmarayappa M.D. 614 Easternshore Dr Salisbury MD 21804 31. Date filed (Month, Day, Year) JUL 1 9 2005 32. Refistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) S. Time of Death **Physician** Month Wallace Nicholas Ward July 2005 3:45p 1 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner P.G. Prince George Hospital 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2□ F 44 UNKNOWN Yrs. Director Wash, D. C. Usual Residence of Decedent with tha Maryland 10c. City, Town or Location Seat Pleasant 10a. State 10b. County 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at P.G. Md. 1√Yes 2 No Director 10e. Street and Number 406-69th Place 10g. Citizen of What Country? 10f. Zip Code permit. Pagas 1 and 2 should be filled within 72 hours after death with Department of Health and Mental Hygiene. Important: If them 27 is marked other than "--- any injury or other traumati-- once. 20743 Itams 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Never Married 2☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify Black 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) A.Ward Seasons Chef 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Aurelia E.Ward Warren N.Ward Sr. ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 406-69Pl Seat Pleasant, Md. 20743 Aurelia E.Ward-Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 7-8-2005 Landover, Md. Harmony Park * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature o Funeral Service Licensee 22. Name and Address of Facility 5635 Eads St, N.E. Dunn & Sons onter the disease, or complications that caused the wath. or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner nsequence of) sician and burial-transit The law requires that the death certificate be axecuted resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an autopsy performs Were autopsy findings available prior to completion of cause of death? certificate 2 No 1 Yes Division of Vital 1 🔲 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one examiner? Other: ပ Yes 2□No 1 Inpatient 2 ☐ ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After thi funeral Manyer of Death Dote I Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Sident investigation hours after death. Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours at To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Pentrying Priyacian: To the best of my knowledge, dearn occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title ot certifier 29d. Date signed (Month, Day, Year) 0 ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add atevenis 31. Date filed (Month, Day, Year) 2005

DHMH 17 Rev 1/2001

Registrar

2 1

ORIGINAL

			1 - For State Registrar	State of Marylan		artment tificate				giene 005	25425
	Dhyoisi	-	1. Decedent's Name (First, Middle, Last	1)					2. Date of De	ath Pay O Near	3. Time of Death
	Physici /Medi		Willie	Wade	:				July	19,2005	11:27P M
7	Examir	ner	4a. Facility Name (If not institution, give	·		_		ocation of Dea	th	4c. County of Dea	
			DOCTORS HOSPITA		t4 t :-4t - ()	LAN If Under	HAM	f Under 24 Hr			GEORGE'S
	Funeral Director		5. Social Security Number 6. Se 18	7. Age (<i>In yrs. I</i>	Yrs.	Months		Hours Mir	. (Month, Da		rthplace (State or Foreign ountry)
			Usual Residence of Decedent	07					April	22 1938 A1	abama
	laryland ehow		10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	e Marfe	ctor	MD Prince G	eorge's	Capito	ol Hei	lghts				1 Yes 2 □ No
	ith th or 28	Funeral Director	10e. Street and Number			10f. Zip	Code			10g. Citizen of What C	ountry?
	ath w	ral	7005 Bishop Drive				2074			U.S.A.	
	er de Items	une	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. V	Nas Decede f Yes, speci	ent of Hisp ify Cuban,	anic Origin? (Mexican, Pue	Specify Yes or No rto Rican, etc.)	14. Race - Am Black, Whi	
36	irs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 K∑Yes 2 □ No AYIII If Yes, Give Year or Dates:	iy .	1 ☐ Yes 2	No :	Specify:		Specify: I	31ack
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ehow te Madical Examirer must be naillied at	led	15. Decedent's Edu	ucation	16a. Deced	dent's Usual	l Occupation	on		16b. Kind of Business	√Industry
215	hin 7;	ple	(Specify only highest grad Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give life. L	kind of worl DO NOT use	k done dur. e retired)	ing most of w	orking		,
21	ad wit	Completed	12th	contage (1 tot o t)	Brick	Maso	n			Private	
pu	2 should be filed within 72 hours after dea and Mental Hygiene. Ie marked other than "natural; or items eumatic event, It e Marical Examirer m	Be	17. Father's Name (First, Middle, Last)							Maiden Sumame)	
yla	Meni Meni arke	ဥ	Cal Wade				5	Sarah	Tolbert		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Department if Item 27 ie marked other than "natural", or items 23e or 28a-f ehov any Injury or other treumatic event, it e Madical Examiner must be notified at Once.		19a. Informant's Name/Relationship (T)	ype, Print)	1					er, City or Town, State,	,
	1 and Health	1 5	Muriel Wade/Wife 20a. Method of Disposition	20h P	/ UU5 lace of Dispo			Lve Cap	itol Hei	ghts, Mary	
Baltimore,	if its		1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	emetery, cren	natory or oti	her place)	!		20c. Location - City or	
ᆵ	it. Pi		* 4 □ Donation 5 □ Other (Specify)) Ma:	ryland				26/05	Cheltenham	
Ba	Depa Impo any i		21. Signatury of disease			. Name and				enkins Fune	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death						er, Marylan	Approximate
8760,	Physician /Medical Examiner potator and physician and physician and the phrial-Itansit	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of the consequence o	vence of): (Anois vence of): Anter	~+·P^		tion			Onset and Death
P.O. Box 68	the death certific by the attending parched for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ∐Live birth 2 ∏ Fetal 4 ∏Pregnant at time of de 9 ∭ Unknown	death 3	Ectopic pre				23d. Date of de Month	livery Day Year
Records, F	w requires that been signed b should be det	Completed by P	Part II. Other significant conditions co Super Ficial Cause	ne of Feet R	ulting in the ur		use given i			obacco use contribute to es 2 No 3 P	o the cause of death?
000	aw requ ss been 2 should	plet	DIABETES Mallitus SICK SINUS SYNON					•	24a. Was		utopsy findings available completion of cause of
æ	hysicien: The law nis certificate has I director, page 2 s	E O	SICK SINUS SYNON	wne						med? death? 24 No 1 ☐ Yes	,
ita	ien: artifica ctor, I	Bec	25. Was case referred to medical examiner?				2	6. Place of De	ath (Check only o		5332
of Vital	Physicien: this certific ral director,	2	1 ☐ Yes 2 🔼 No		ER/Outpatien	t 3 DO	A Other:	4 Nursing	Home 5□Resid	lence 6 Other (Spe	ocify)
טע	ding Ph h. After thi funeral	i.i	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28	c. Injury at Work?	t	28d. Describe f	now injury occurred	
Division	Attending r death. sector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be			М		s 2 No			
Ξ	or At after d Direct in by	E	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory,	office		28f. Location (S City or Tox	Street and Number or R m, State)	ural Route Number,
	urs a		120-14-5						1		
	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the f	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exemi	rsician: To the best of my know iner: On the basis of examinat and manner stated.	wledge, death tion and/or inv	occurred a restigation,	it the time, in my opini	date and plaction, death occ	e, and due to the urred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	o the ithin o the omple	Me	29b. Signature and title of certifier	and manner stated.		29c.	License n	umber		29d. Date signed (Mon	th, Day, Year)
			1 AAA	a hun				2358		7/19/05	
	5		30. Name and address of person who co	leted cause of death (Item	23a) (Tyne						
	(b)		BAINNS BAYLY. M.		AN OVER	pku	4 6	neenoc	IT MA	20770	
Ī	Sta Registi	-	JUL 2 1 2005	32. Raģistrar's Signa	ure						

	1 - For State Registrar	State of Mar	•	rtificate of			g. No.						
/sician	1. Decedent's Name (First, Middle					2. Date of Death Month	Day Z U Yea	3. Time of Death)					
ledical	Thomas M. Wil					July 15	, 2005	3:40 A M					
aminer	4a. Facility Name (If not institution			1	Location of Death		4c. County of De						
	Holy Cross Ho 5. Social Security Number		(In yrs. last birthday)	Silver	Spring If Under 24 Hrs.	8. Date of Birth	Montg	omery inhplace (State or Foreign					
eral ctor	153-18-5740	√VTM o□ E	84 Yrs.	Months Days	Hours Min.	Jan. 1,	Year) (W Jersey					
	Usual Residence of Decedent					, , ,		00150)					
d -	10a. State 10b. County	1	Oc. City, Town or Lo	ocation				10d. Inside City Limits					
ecto	D.C. N/A		Washin			1		Y Yes 2 No					
nner must be notified at	10e. Street and Number 1817 Tulip Str	eet N.W.		10f. Zip Code 20012		10	g. Citizen of What (United S	•					
era	11. Marital Status	-	er in U.S. 13.		ispanic Origin? (Sp	ecify Yes or No-		nerican Indian,					
翼 点	1 ☐ Never Married 2 🛣 Marr			Was Decedent of H If Yes, specify Cuba		Rican, etc.)	Black, Wh						
by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1946	1 ☐ Yes 2 No	Specify:		Africa	n American					
etec	15. Deceden (Specify only higher	t's Education st grade completed)	16a. Dece (Give	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of work	ing 1	6b. Kind of Busines	s/Industry					
Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)					Mo. J. d 1						
S	17. Father's Name (First, Middle,		Der	matologis		e (First, Middle, M	Medical						
To Be					Mary Bu								
T T	19a. Informant's Name/Relations		19b. Maili	ng Address (Street			City or Town, State	, Zip Code)					
	Ruth Ann Willi	ams (wife)	1817	Tulip St	reet, N.	W Washi	ngton. D	.C. 20012					
	20a. Method of Disposition 1 XBurial 2 ☐ Cremation	V75	20b. Place of Dispo				0c. Location - City of						
\$ D	`4 □ Donation 5 □ Other (S		Greenwoo	d Cemeter	y 7/22	/05 Tr	enton, N.	J					
any injury or other traumatic event, the Michigan Exponse.	21. Signature of Funeral Service	Licensee /	2	2. Name and Address	ss of Facility Mc	Guire Fur	eral Ser	vice					
5 O	Thomas	D. Con		400 Georg									
	23a. Part1. Enter the disease, or shock, or heart failure. List	complications/that caused the only one cause on each line.	ne death. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death					
an : cal	Immediate Cause (Final disease or condition resulting in death)	Sepsis						days					
er			consequence of):					days					
و <u>ا</u>	Sequentially list conditions, if any, leading to immediate Urinary tract infection Due to (or as a consequence of):												
xaminer	cause. Enter Underlying Cause (Disease of Injury that initiated events	С.						l.					
i iii	resulting in death) Last	Due to (or as a d	consequence of):										
licai		d											
Med	IF FEMALE:												
lan/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	Fetal death 3	Ectopic pregnancy			23d. Date of d Month	elivery Day Year					
- 77	1 ☐ Yes 2 ☐ No	4☐ Pregnant at tin 9☐ Unknown	ne or deam 5 L	Other (specify)									
ysici	9 LI UNKNOWN												
-		ons contributing to death but	not resulting in the u	inderlying cause give	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to								
by	Part II. Other significant conduit		not resulting in the u		an in Part I.			Probably 4X Unknown					
by	Part II. Other significant conduit				an in Part I.	1 ☐ Yes 24a. Was an	2 No 3 F	autopsy findings available					
pieted by	Part II. Other significant conduit				en in Part I.	1 ☐ Yes 24a. Was an autopsy perform	2 No 3 P	autopsy findings available completion of cause of					
e Completed by	Dehydration 25. Was case referred to medical					1 ☐ Yes 24a. Was an autopsy perform	2 No 3 F 24b. Were a prior to death? No 1 Ye	autopsy findings available completion of cause of					
Be Completed by	Dehydration 25. Was case referred to medical examiner? 1 Yes 2 XNo				26. Place of Deat	1 Yes 24a. Was an autopsy perform 1 Yes X	2 No 3 P 24b. Were a prior to death? 1 Ye	autopsy findings available completion of cause of					
n: To Be Completed by	Dehydration 25. Was case referred to medical examiner?	Hospital: 1 X Inpatient	2 ☐ ER/Outpatier	nt 3 DOA Othu	26. Place of Deat er: 4 □ Nursing Ho v at	1 Yes 24a. Was an autopsy perform 1 Yes X	2 No 3 F 24b. Were a prior to death? No 1 Ye Ce 6 Other (Sp	autopsy findings available completion of cause of					
n: To Be Completed by	Dehydration 25. Was case referred to medical examiner? 1 Yes 2 X No 27. Manner of Death 1 X Natural 5 Pendin investig	Hospital: 1 X Inpatient 28a. Date of Injury (Month, Day Y	2 ☐ ER/Outpatier 28b. Time o Injury	nt 3 DOA Othi	26. Place of Deat er: 4 ☐ Nursing Ho r at r? Yes 2 ☐ No	1 Yes 24a. Was an autopsy perform 1 Yes X n (Check only one me 5 Residen 28d. Describe how	2 No 3 F 24b. Were a prior to death? No 1 Ye Cee 6 Other (Sp	autopsy findings available completion of cause of s 2 No					
n: To Be Completed by	Dehydration 25. Was case referred to medical examiner? 1	Hospital: 1 X Inpatient 28a. Date of Injury (Month, Day Y	2 ☐ ER/Outpatier 28b. Time o Injury	nt 3 DOA Othi	26. Place of Deat er: 4 ☐ Nursing Ho r at r? Yes 2 ☐ No	1 Yes 24a. Was an autopsy perform 1 Yes X n (Check only one me 5 Residen 28d. Describe how	2 No 3 F 24b. Were a prior to death? No 1 Ve ce 6 Other (Sp	autopsy findings available completion of cause of					
n: To Be Completed by	Dehydration 25. Was case referred to medical examine? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin investic 2 Accident investic 3 Suicide 6 Could referred to medical examine? 4 Homicide	Hospital: 1 X Inpatient 28a. Date of Injury (Month, Day Y gation not be ined 28e. Place of Injury building, etc.	2 ☐ ER/Outpatier 28b. Time o Injury - At home, farm, str (Specify) my knowledge, deat	nt 3 DOA Other 28c. Injury Work M 1 Toreet, factory, office	26. Place of Death 9r: 4 □ Nursing Ho r at r? Yes 2 □ No	1 Yes 24a. Was an autopsy perform 1 Yes	2 No 3 F 24b. Were a prior to death? No 1 Ve Ce 6 Other (Sp injury occurred	autopsy findings available completion of cause of s 2 \(\text{No} \) ecify) Rural Route Number,					
n: To Be Completed by	Dehydration 25. Was case referred to medical examine? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin investic 2 Accident investic 3 Suicide 6 Could referred to medical examine? 4 Homicide	Hospital: 1 X Inpatient 28a. Date of Injury (Month, Day Y	2 ER/Outpatier 28b. Time o Injury 7 - At home, farm, str (Specify) my knowledge, deat kamination and/or in	nt 3 DOA Other 28c. Injury Work M 1 Toreet, factory, office	26. Place of Death 9r: 4 □ Nursing Ho r at r? Yes 2 □ No	1 Yes 24a. Was an autopsy perform 1 Yes	2 No 3 F 24b. Were a prior to death? No 1 Ve Ce 6 Other (Sp injury occurred	autopsy findings available completion of cause of s 2 \(\text{No} \) ecify) Rural Route Number,					
To Be Completed by	Dehydration 25. Was case referred to medical examiner? 1	Hospital: 1 💥 Inpatient 28a. Date of Injury (Month, Day) gation not be ined 28e. Place of Injury building, etc. g Physician: To the best of examiner: On the basis of examiner state	2 ER/Outpatier 28b. Time o Injury 7 - At home, farm, str (Specify) my knowledge, deat kamination and/or in	nt 3 DOA Other 28c. Injury Work M 1 Toreet, factory, office	26. Place of Death ar: 4 ☐ Nursing Ho r at r? Yes 2 ☐ No	1 Yes 24a. Was an autopsy perform 1 Yes M (Check only one me 5 Residen 28d. Describe how 28f. Location (Stre City or Town, and due to the caued at the time, dat	2 No 3 F 24b. Were a prior to death? No 1 Ve Ce 6 Other (Sp injury occurred	autopsy findings available completion of cause of is 2 \(\sum \) No ecify) Rural Route Number, as stated. be to the cause(s)					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar Suresh K. Gupta,
31. Date filed (Manth, Day, Year)
JUL 19 2005

M.D. 9801 Georgia
32 Registrar's Signature Avenue Suite 220, Silver Spring, MD 20912

MD

rson who completed cause of death (Item 23a) (Type, Print)

D 32332

July 16, 2005

			State	of Manuand / Don	artment of Health and N	•	•
			For State Registrar		ertificate of Death		200 =
			Decedent's Name (First, Middle, Last)		Timeate of Death	Reg. Na	3. Time of Death
	Physic		1111	Moaney V	Villiams	Month Da	ly Year
	/Medi Examir		4a. Facility Name (If not institution, give street and		4b. City, Town, or Location of Death	July 14	1 2005 4:55 AMM County of Death
1	LXuiiii		Genesis HealthCare				Talbot
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
	Director		214-34-5453 10M 21D	F 68 Yrs.	Months Days Hours Min.	Aug. 291	936 Maryland
	pug *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation	3 /	tod basida On Com
	Aaryla I sho	ត	112				10d. Inside City Limits 1 🗍 Yes 2 🗗 No
5	28a-	ect	/// / Talbot 10e. Street and Number	Ea	S+0N 10f. Zip Code	ton Ci	
5	with Sa or	Ö	P. O. BOX 412		21601	Tog. Ci	tizen of What Country?
3	death with the Maryland rms 23a or 28a-f show rmust be notified at	Funeral Director	11. Marital Status 12. Was	Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puento	pecify Yes or No-	14. Race - American Indian,
9	after or ite		1 Never Married 2 Married 1 □ Y	es 2 1/2 No	~ ~	Rican, etc.)	Black, White, etc.
5-0036	be filed within 72 hours after death with the Marylan stal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced Year	or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Black
5-	natu	Completed	 Decedent's Education (Specify only highest grade complete 	ted) 16a. Dece	edent's Usual Occupation a kind of work done during most of work DO NOT use retired)	king 16b. K	(ind of Business/Industry
121	within lene. than "	E		ge (1-4or5+) .			1-0:11
d 21	Hygie ther ther		17. Father's Name (First, Middle, Last)	Opera	ating Room tech	nician /-	fosp, Tal
land	should be filed within of Mental Hygiene. marked other than matic event, the Marit	To Be	William Henry	Moaney	SR. Anna	Elizaber	li lavic
Mary		-	19a. Informant's Name/Relationship (Type, P t)		ing Address (Street and Number or Rui	ral Route Number, City of	or Town, State, Zip Code)
Σ	alth ar 27 is or trau		Howard William			on, Mary	1
ore.	of Healt fitem 2 r other		20a. Method of Disposition	20b. Place of Disp	osition (Name of	Date 20c. Lo	ocation - City or Town, State
<u>E</u>			1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fi 1 ☐ Donation 5 ☐ Other (Specify)	rom State	ville Cemetery 7/	21/05 Ea	Ston Maryland
Baltimor	permit. Pag Department Important: any injury c		21. Signature of Funeral Service Licensee		2. Name and Address of Polity Yenry Funeral H	hme. P.A.	1000
ш	20599		Janelle C. o	70,000	10 Washington	St, Cambr	idae, MD. 21613
			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause	nat caused the death. Do not en on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	obable acul	e cormany the	0W/18915	Onserand Death
	Examiner		Due	to (or as a consequence of):	1./	/n. 1.	1.00
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	to (or as a consequence of):	e condiditionin	1000 0134	are years
	sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events				•
oʻ	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit		ropulting in dooth) Loot	e to (or as a consequence of):			
8760	ate be ex hysician the burial	icai	d				
9	ntifice ing pt	Physician/Med	IF FEMALE:				
Вох	eath certific attending pl for use as t	an/l	23h Was decedent pregnant 23c. If yes	outcome of pregnancy ve birth 2 Petal death 3	DEctopic pregnancy		23d. Date of delivery
	at the dea by the al	sici	1 Yes 2 No 4 P		Other (specify)		Month Day Year
P.0	that the		Part II. Other significant conditions contributing	to death but not reculting in the	underheine agus agus in Best I	22a Did tehases	use contribute to the cause of death?
Vital Records,	signe d be	d by	Dialeste	and Wille	mosnymy cause given in Part I.		No 3 Probably 4 Unknown
Ö	w require been signature	ete	10 101	· · ·			
Rec	The lav	ompieted	- Mary	12		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
G		င်	25. Was case referred to medical	Variable	direct	1 Yes 2 No	1 ☐ Yes 2 ☐ No
	Physician: this certific ral director,	0	examiner?	☐ Inpatient 2 ☐ ER/Outpaties	Other	h (Check only one)	
of	g Phy ler this		27. Manner of Death 28a. D	ate of Injury 28b. Time of		ome 5 Residence 28d. Describe how injur	
ion	를 돌 후	atio	1 ☐ Natural 5 ☐ Pending (fine 2 ☐ Accident investigation	Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		
Division	er de er de recto by th	Certification	3 ☐ Suicide 6 ☐ Could not be determined 28e. P	lace of Injury - At home, farm, st uilding, etc. (Specify)	reet, factory, office	28f. Location (Street an City or Town, State	nd Number or Rural Route Number,
Ö	ital or rs aft all Di	Cer					
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edicai	Z medical examiner: On it	ie dasis of examination and/or in	h occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cause(s) red at the time, date and	and manner as stated. I place, and due to the cause(s)
	thin 2 the mplet	Med	one) and n	panger stated.	29c. License number		
	5 7 ½ J		I WANT	Y MID	1)257.7	29d. Dai	te signed (Month, Day, Year)
7	i		30. Name and address of person who completed of	rause of death (Item 22a) 77	Drint)	- 1//	1/00
			ROBERT SANCHER M	D 508 This	FWILD AVE	EASTON 1	na 21601
	Sta	te	4	2. Pegistrar's Signature	1 4.		
	Registr	ar	HIV 1 9 2005	Marian Marian	0945kJ		

Alethia Williams

within 24 hours after deatl To the Funeral Director; completely filled in by the the Hospital

> State Registrar DHMH 17 Rev 1/2001

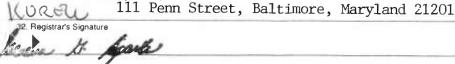
29a. Certifier

Medical

29b. Signature and title of certifier

11XMANIO

31. Date filed (Month, Day, Year)



of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

July 31, 2005

			For State Registrar	State of	Maryland / Depa <i>Ce</i>	artment of He		, ,	ene Manns	25120			
	Physici		Decedent's Name (First, Middle, TRACY E. ALSTON	Last)				2. Date of Death Month	Day Year 2005	3. Time of Death			
>	/Medic Examin		4a. Facility Name (If not institution, WASHINGTON COUNTY H		er)	4b. City, Town, or	Location of Death	0	4c. County of Deat	h			
	Funeral Director		220-92-4668	. Sex 7. 1 X M 2 □ F	Age (In yrs. last birthday) 39 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y AUG 31, 19	(ear) 9. Birt	hplace (State or Foreign funtry) LAND			
	aryland show	_	Usual Residence of Decedent 10a. State 10b. County MARYT AND NA		10c. City, Town or Lo					10d. Inside City Limits 1 XYes 2 □ No			
	vith the Mi or 28e-f	Directo	MARYLAND NA 10e. Street and Number 1510 MOSHER STREET	ΔΡΤ 5Δ	DALITIO	10f. Zip Code 21217		109	p. Citizen of What Co USA				
(0	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental thygiene. If item 27 is marked other then "naturel", or items 23e or 28e-f show or other traumatic event, the Marked Examinate in building at	Funeral Director	11. Marital Status 1 □XNever Married 2 □ Married	12. Was Decede	es?	Was Decedent of His If Yes, specify Cubar	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	oncan Indian, e. etc FRICAN			
21215-0036	72 hours naturel',	eted by	3 Widowed 4 Divorced 15. Decedent's (Specify only highest	If Yes, Give Year or Date Education grade completed)	98: 16a. Dece	1 ☐ Yes 2 🔀 No Ident's Usual Occupa Identify the desired of work done do	Specify: tion uring most of work	ing 16	AMERICAN 16b. Kind of Business/Industry				
2121	led within ygiene. her then "	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	WORKED							
, Maryland	iould be fi I Mental H harkad otl hatic ever	To Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)										
	and 2 sh lealth and m 27 is m		19a. Informant's Name/Relationship DORIS LARKINS	o (Type, Print)	1510	MOSHER STREE	T APT. 5A	BALTIMORE	, MARYLAND 2	21217			
altimore,	P. In P. In		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		ate 20b. Place of Disposementary, cre	matory or other place	AUG 2,	2005 B	ALTIMORE, MA				
Bal	permit. Departr Importe any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility WYLIE FUNERAL HOME P.A. 638 N. GILMOR STREET BALTIMORE, MARYLAND 21217										
	Pnysician		23a. Part1. Enter the disease, or c shock, or heart failure. List or Immediate Cause (Final disease or condition	omplications that cause on each	ised the death. Do not en	ter the mode of dying Faili		or respiratory arres	t,	Approximate Interval Between Onset and Death			
	/Medical Examiner		resulting in death) Sequentially list conditions,	b	as a consequence of):					lw			
V .	xecuted and al-transit	Examiner	if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last		154								
68760,	ficate be executed physician and sthe burial-transit	dicai		d.									
.O. Box	The law requires that the death certifi site has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ∏Fetal death 3 (nt at time of death 5 (23d. Date of del Month	23d. Date of delivery Month Day Year				
Δ.	quires that (n signed by uld be deta	by	Part II. Other significant conditions contributing to death out not resulting in the underlying cause given in Part I.										
I Records,		Completed		prior to death?									
of Vital	ding Physicien: Th n. After this certificate funeral director, pag	To Be	25. Was case referred to medical examiner? 1 \(\sum \text{Yes} \) 2 \(\sum \text{No} \) No	Hospital: 1 💢 Inp	patient 2 ER/Outpatie	ont 3 DOA Othe	26. Place of Death (Check only one) OCA Other: 4 Universing Home 5 Residence 6 Other (Specify)						
Division o	ding After fune	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga		at ? ′es 2 □ No	28d. Describe how injury occurred							
DIX	itel or Attenurs after deatl rel Director: lled in by the												
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	Aedicai	one)	Physician: To the b caminer: On the bas and manne	est of my knowledge, dea is of examination and/or in r stated.	nvestigation, in my op	oinion, death occur	red at the time, dat	e and place, and due	to the cause(s)			
)	To with To	M	29b. Signature and title of certifier	u E	3	29c. License	2323	290	1. Date signed (Mont	signed (Month, Day, Year)			
	7		30. Time and address of person w	ho completed cause	of death (ttern 23a) (Type	Print)	Hoy . Mc	1 217	40				
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Reg	of death (ttem 23a) (Type	المنا	(

ORIGINAL

			1 - For State		f Maryland	/ Depa	artment	of H	ealth a		-		000	05100		
			1 - State Registrar 1. Decedent's Name (First, Midd	lo (ast)		_Ce	rtificate	OIL	Jeain -	T	2. Date of De	Reg. No.	2005	45430		
	Physici		Theodore	Buptiste	,						Month	Day		3. Time of Death		
,	/Medic Examir		4a. Facility Name (If not institution		4b, City, 1	Town, or	Location o	of Death	راسال	29	County of Deal					
	Exami	er	Levindale Nu				Bal					10.	county of Deal			
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last	birthday)	If Under	1 Year	If Under 2	24 Hrs.	8. Date of Bir (Month, Da	th Your	9. Birt	hplace (State or Foreign		
	Director		174-52-1493	1 X M 2 □ F	84	Yrs.	Months	Days	Hours	Min.	05 2			t Indies		
	pur *		Usual Residence of Decedent 10a. State 10b. Count	,	10c. City, T	own or Lo	ocation							10d Incide City Limite		
	Aaryik I sho	ō		•	,									10d. Inside City Limits 1 X Yes 2 □ No		
	28a-	rect	MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What									zen of What Co				
	3a or	<u>=</u>	4210 Newbern Ave 21215 U.S.A.										,			
	death	by Funeral Director	11. Marital Status	13.	Was Deced	ent of His	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)	- 1	14. Race - American Indian,					
9	after or its	正	1 ☐ Never Married XXMar	If Yes Giv	2 💢 No		1 ☐ Yes 2		Specify:	i, Puerto F	rican, etc.)		Black, White			
8	ural',	qp	3 Widowed 4 Divorced	Year or Da	ates:						·	Specify: Black				
<u>7</u>	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-1 show ha Medical Exama na routil be notified at	Completed	15. Deceder (Specify only highe	6a. Dece	dent's Usual kind of worl DO NOT use	l Occupa k done di	tion u <i>ring m</i> ost	of working	g	16b. Kir	6b. Kind of Business/Industry					
7	withi iene. than	шо	7th grade	College (1	-4or 5+)		inte					Notr	e Dam	e College		
<u> </u>	Hygie other	Be C	17. Father's Name (First, Middle,							r's Name	(First, Middle,					
ılar	uld be Aenta rkad tic ev	ToB	Righton Bapt	iste				ľ	Miska	a P	ascal					
Maryland 21215-0036	permit Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumetic event, the Medical Exame nor from the multilled at ODCs.		19a. Informant's Name/Relations	ship (Type, Print)									Town, State, Z	Zip Code)		
	and sealth m 27		Patricia Bap	tiste-Wi							altim			21215		
Baltimore,	ges 1 t of H if ital		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Removal from	State 20b. Place	e of Dispo etery, crei	sition (Nam matory or ot	e of her place)	Da	ate	20c. Lo	cation - City or	Town, State		
Ē	rmen rent:		1 Burial 2 □ Cremation 3 □ Removal from State 1 Onation 5 □ Other (Specify) 1 Onation 5 □ Other (Specify) 1 Onation 5 □ Other (Specify)										le, Md			
Bal	Depariment Department of the policy in policy in policy in policy in policy in policy in policy in policy in policy in policy.		21. Signature of Funeral Service	Licenses	6	M	2. Name and larch	F/E	H Wes	st.						
			25a. Part 1. Enter the disease, o	r complications that c	aused the death. [4	300	Waba	ash /	Ave,	Balt	imor	ce, 21	215 Approximate		
	, ,		shock, or heart failure. Lis Immediate Cause (Final	t only one cause on e	ach line.			oraying	P A	4	respiratory at	11031,		Interval Between Onset and Death		
	Physician /Medical		disease or condition resulting in death)	a. Acir	or as a consequence	Car	dial	(N	ave	DI						
	Examiner			, ,	3 Mary	1	eva	dise	a Ca					3.6		
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		or as a consumen	ce of):	0	CILL	11.75					gears		
V	cuted nd ransit	Examiner	that initiated events	1.000												
Ó,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a consequent	ce of):										
8760,	icate b physic s the bi	dicai		d												
9	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:	23c If yes out	come of programmy											
Вох	atten for us	ian	23b. Was decedent pregnant in the past 12 months? 1 Very 2 No. 1 Pregnant at time of death 5 Other (speci									2	very Day Year			
o.	the d	ıysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unkno		. 3	1 Other (spe	City)		1000						
<u>.</u> ت	wrequires that the de been signed by the s should be detached	by Pł	Part II. Other significant conditi	ons contributing to de	ath but not resultin	g in the u	nderlying ca	use givei	n in Part I.		23e. Did to	obacco us	se contribute to	the cause of death?		
Records,	quires in sig uld be	q pa	Diabetes Mellitus, Stroke, prostute Cancer 10 You								/es 2	(No 3□Pro	obabiy 4 Dunknown			
000	aw re s bee 2 sho	plet	Hypertension	Demen	t.	J						24a. Was an 24b. Were autopsy findings availa				
	The la	Completed	Ja	, , , , , , , , ,	10.00						autop perfo	rmed?	death?	ompletion of cause of 2 No		
ita	Physician: The lav this certificate has al director, page 2	Be C	25. Was case referred to medica examiner?	1		35		-	26. Place	of Death	Check only o	100	1 1 1 1 1 1 1 1			
<u>></u>	hysic his ce I dire	၉	1 ☐ Yes 2 XNo			Outpatien	ıt 3□ DOA	Other	r: 4 Nur	sing Hom	e 5 Resid	dence 6	□Other (Spec	ify)		
בַ	ing P	on:	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred													
Sio	ttand death tor: /	cati														
Division of Vital	or A	ertif	4 Homicide determ	nined 286. Place buildir	of Injury - At home, ng, etc. (Specify)	, tarm, str	eet, factory,	office		2	City or Tou	vn, State)	Number or Ru	ral Route Number,		
	spitel ours ours naral filled		29a. Certifier 15 Certifyi	ng Physician: To the	best of my knowled	dae. death	n occurred a	t the time	date and	d place, as	ad due to the	causa(s) s	and manner as	stated		
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director.	Medical	(Check only 2 Medical one)	Examiner: On the ba	isis of examination	and/or in	vestigation, i	in my opi	inion, death	h occurre	d at the time,	date and	place, and due	to the cause(s)		
	To th withir To th comp	Me	29b. Signature and title of certifie	•				License				29d. Date	signed (Month	, Day, Year)		
)			A. Muze	um; M	>			D 60	170			7/	29/25			
			30. Name and address of person			a) (Type,	Print)									
_	3		A. Ghazinouri		ndali											
	Sta Registr		AUG 0 4	2005 2. R	egistrar's Signature	Gos	W									
	. negisti	ųι	AUG U 4	LUCU PURE												

DHMH 17 Rev 1/2001

Baptiste, Theodore

			For State Registrar	State o	f Maryla		artment of			lental Hyg	jiene	15	251.	31	
	Physicia	an	1. Decedent's Name (First, Middle, Last	·						2. Date of Dea Month	th	Year	3. Time of	i Death	
	/Medic	al -				Brown				August	2, 2005		6:10	A M	
	Examin	er	4a. Facility Name (If not institution, give 802 Templecliff I		mber)			n, or Location of $11 ext{timore}$			4c. County o		more		
	Funeral		5. Social Security Number 6. Se	x	7. Age (In yr	s. last birthday)	If Under 1 Ye	ear If Under	24 Hrs.	8. Date of Birth	1	9. Birthp	lace (State o	or Foreign	
	Director		217-10-7936	JM 200 F		99 Yrs.	Months Da	ys Hours	Min,	JUN 18,	1906	1906 Mary			
	land land		Usual Residence of Decedent 10a. State 10b. County		10c. 0	City, Town or Lo	cation					1	0d. Inside Ci	ity Limits	
	Mary a-f sh	tor	Maryland Balti	more]	Baltimo	re				1 ☐ Yes	2 X No	
	th the or 284	Funeral Directo	10e. Street and Number				10f. Zip Cod			1	l0g. Citizen of W	hat Cour	ntry?		
	ath w	ral	802 Templecliff	212				USA	1						
	items items items	nne	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Fo		U.S. 13.	Was Decedent of f Yes, specify C	of Hispanic Ori Cuban, Mexican	gin? (Sp 1, Puerto	ecify Yes or No- Rican, etc.)		 Race - American Indian, Black, White, etc. 			
920	ursaf	by	3.X Widowed 4 □ Divorced	If Yes, Gir Year or D	1 ☐ Yes 2 🗖 No If Yes, Give X Year or Dates:			No Specify:			Specify:	Specify: White			
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f show the Maryland Examination or the mailling at	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)			dent's Usual Oc kind of work do		t of work	ina	16b. Kind of Bus	siness/In	dustry		
12	within ane. than '	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use re	tired)			0				
о О	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, ITEM.	Be Co	17. Father's Name (First, Middle, Last)			-	Homemak		r's Nam	e (First, Middle,	Own] Maiden Sumame				
Maryland	should be and Mental s marked c umatic eve	To B	John Hook						Br	idget O	rmond				
lar	2 sho and h is ma	ľ	19a. Informant's Name/Relationship (T	ype, Print)		19b. Mailir	ng Address (Str	eet and Numbe			r, City or Town, S	State, Zip	Code)		
e) S	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, It a Modest Examinet is use by notified an once.		Mary Ellen Heinle: 20a. Method of Disposition	in/Daug		4570 Place of Dispo	Meghan			tavia, I	H 4510				
nor	ages int of l t: if ite y or o		1 ☐ Burial 2 🂢 Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Removal from	State	cemetery, crei	natory or other	place)				-			
Baltimore,	mit. Poartme	1	21. Signature of Superal Service License		1*16	etro Cro	Name and Ad	, INC	8/3/ y .	of MD,	Balti -	more	MD		
Ö	Dermi Depa impo any ir		Edward A. Sp	egorch:	ik		cremati 299 Fre	on Soci derick	Lety Road	ot MD, 1 Baltim	Inc. ore, MD	212	28		
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that one cause on e	caused the de each line.								Approximat Interval Bet Onset and I	ween	
	Physician /Medical	1	Immediate Cause (Final disease or condition resulting in death)	a	Breas		ncer						Onset and i	Doalli	
Е	Examiner			Due to	(or as a cons	equence of):									
7	P .=	ner	Sequentially list conditions, cause. Enter Underlying	b. Due to	(or as a cons	equence of):									
V	ecuter and -trans	Examine	Cause (Disease or injury that initiated events c												
8760,	cate be executed obysician and the burial-transit	dlcal E		504.0	(OI as a COIIsi	equerice or).									
9	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ledic		d											
Вох	eath certific attending p I for use as I	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 manths? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy									of delivery			
0.	he dea the at	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregr 9□ Unkn	nant at time of own		Other (specify				Mon	Month Day Year			
, P.O.	res that the deigned by the be detached		Part II. Other significant conditions co	ntributing to d	eath but not re	esulting in the u	nderlying cause	given in Part I.		23e. Did to	bacco use contri	bute to th	e cause of d	feath?	
rds	w requires been sign should be	ed by	Mulfisysten Organ tailare 1 Yes 20								es 2□No	□No 3 □ Probably 4 □Unknown			
eco	e law requ has been je 2 shouli	Completed	Merifisysten Organ Failure Essential Hypertension 24a							24a. Was a autops					
Vital Records,		Con								perform	med2 de	eath?		2200 01	
Ĭ Ĭ	ysiclan: Th is certificate director, pag	o Be	25. Was case referred to medical examiner?	Hospital:			at 3□ DOA			h (Check only on					
ō	Attsnding Physician: r death. sctor: After this certific by the funeral director,	-	27. Manner of Death	17. Manger of Death 28a. Date of Injury 28b. Time							dence 6 Other (Specify)				
ion	death. ctor: Aft	atlo	1 Matural 5 ☐ Pending investigation	(Mon	in, Day Fear)	Injury		njury at Work? 1 □ Yes 2 □ I	No						
Division of	i or Attsnd after death Director: A	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	eet, factory, offi	ice		28f. Location (Si City or Town	Street and Number or Rural Route Number, vn, State)							
	Hospital of the hours af Funeral Distributed in the hours af Euneral Distributed in the hours after the hours		29a. Certifier 1 Certifying Phy	/sician: To the	hact of mul-	nowledge death	a accuracy at the	a time data s-	d place	and due to the	21100/6\ === -	0000	atad		
	To the Hospital or Attsni within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Exam	mer: On the b	asis of exa <i>m</i> i ner stated.	nation and/or in	vestigation, in m	ny opinion, deal	th occur	red at the time, d	ate and place, a	nd due to	the cause(s	;)	
	To the l within 2. To the I	M	29b. Signature and title of certifier				29c. Lic	ense number	i	2	9d. Date signed	(Month,	Day, Year)		
)			> MMSno				D	3368	1	I.	August	2,	2005		
7	5		30. Name and address of person who d	Y , 1	se of death (It	em 23a) (Type, Pregre S	s Hay	, Svite	114	Élden	August Shury N	iD -	21784		
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 4 2(05 32.	egistrar's Sig	nature	sele								

			1 - For State Registrar	State of	Maryland / [Depa <i>Cei</i>	artment <i>tificate</i>	of H	ealth a Death	and Me		giene Reg. No.	005	251	32
	Physici		oditie n. Ddubiica								2. Date of Dea August		005 ^{Year}	3. Time 5: 29	of Death A M
}	/Medio Examir	4.	4a. Facility Name (If not institution	n, give street and nun	nber)		4b. City, T	Town, or	Location o	of Death		4c. C	ounty of Death		
			Union Memorial				Ba1t						N/		
	Funeral Director		5. Social Security Number 215-96-2233	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. last bin 26	thday) Yrs.	If Under 1 Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da) June 14	y, Year)		place (State intry) yland	or Foreign
	and and] }	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Lo	cation							10d. Inside	City Limits
	Maryl -f sho	ğ	Maryland N/A		Balt:										s 2 No
:	or 28e	irec	10e. Street and Number				10f. Zip (Code				10g. Citize	n of What Cou	intry?	
	23a c	aiD	4128 Buena Vist	a Avenue				2	1211			USA	A		
936	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. A file in 27 is marked other than "natural", or items 23a or 28e-f show or other traumatic event, the Madical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Marria 3 Widowed 4 XDivorced	ried Armed For	2 X∑X No 9	1	Vas Decede í Yes, speci I □ Yes 2		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto R	cify Yes or No- Rican, etc.)		. Race - Ameri Black, White pecify: Wh		
21215-0036	n 72 hou	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	nt's Education st grade completed)		(Give	lent's Usual kind of work DO NOT use	k done d	urina most	of workin	g	16b. Kind	of Business/Ir	ndustry	
S.	od with	Com	9	College (1	40(5+)	(Cashie	er				Farm	Store		
pu	be file	Be	17. Father's Name (First, Middle, Howard Gary Me							r's Name Eve	(First, Middle,		umame)		
Maryland	I 2 should be filed within a hand Mental Hygiene. I is marked other than "risaumatic event, the Medical market."	မ	19a. Informant's Name/Relations		10h	Mailir	a Addross	(Street 2				C C O	own, State, Zi	n Codel	E- 1179
Ma	nd 2 suith an 27 ls i		Eve Wood	Mother	130.							-			1225
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tra once.		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S	3 □Removal from S	State Metro	Y. LIGI	IDLUIY UI UU	ioi piace			2005		iore, tion City or T isville		1225
Balti	permit. Departm Importe any inju		21. Signature of Funeral Service	Licensei Licensei	<i>s</i>)	22 bi	Name and	Addres	s of Facility S-So Road	itz F			, Inc.		
			23a. Part1. Inter the disease, or shock, or heart failure. List	complications that ca	used the death. Do r	not ent	er the mode	of dying	, such as	cardiac or	respiratory ar	rest,	1	Approximater Appro	ate etween
F	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	rrhos	15	0	(de	Jes				Onset and	Death
	Examiner		Tooling in down,	Due to (or as a consequence of	of):									
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of injury	b. Due to (or as a consequence of	of):									
V	be executed ician and burial-transit	Examiner	Cause (Disease of injury that initiated events resulting in death) Last	c											
8760,	ate be ex hysician a the burial	al E	resorting in coatry Last	Due to (or as a consequence o	of):									
687	phys phys sthe	edical		d											
О. Вох	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mounts? 1 ☐ Yes 2 Mo 9 ☐ Unknown	1 ☐ Live bi	come of pregnancy orth 2 Fetal death ant at time ot death wn		Ectopic pre Other (spe					230	d. Date of deliv Month	ery Day	Year
Records, P.	uires that the de i signed by the id be detached	by	Part II. Other significant condition	ons contributing to de	ath but not resulting in	the ur	nderlying ca	use give	n in Part I.		23e. Did to		contribute to t	he cause of	
COL	s been si	oiete									24a. Was	an 2	24b. Were auto	opsy finding	s available
Re	The lay	Completed									autop perfor	sv 📗	prior to co death? 1 ☐ Yes	in noitetam	cause of
		BeC	25. Was case referred to medica examiner?								(Check only o	ne)			
of V	Physicien: this certific ral director,	P	1 ☐ Yes 2 ♠No		patient 2 DER/Ou								Other (Speci	fy)	
	After funera	tion:	27. Manner of Death 1 Natural 5 Pendir 2 Accident investi	ig .		ime of njury	M 28	c. Injury Work	at ? es 2 □ N		8d. Describe h	now injury o	occurred		
=	il or Attending after death. I Director: After d in by the fune	Certification:	2 Accident Investig	not be 28e. Place	of Injury - At home, fai g, etc. <i>(Specify)</i>	rm, str				_	8f. Location (S City or Tow		Number or Run	al Route Nu	mber,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical Co	29a. Certifier 1 Certifyir (Check only one) 1 Medicel	ng Physicien: To the Exeminer: On the ba and mann	sis of examination and	, death d/or inv	occurred a restigation, i	t the time	e, date and inion, deat	d place, ar h occurred	nd due to the o	cause(s) and date and pl	nd manner as s ace, and due t	tated. o the cause	(s)
	To the complete	Me	29b. Signature and title of certifie	inh	4 5		29c.	License	number		4	29d. Date s	igned (Month,	Day, Year)	
			And	uxee	alm)	-		2	67.	48		818	2120	01	
	7		30. Name and address of person ANIL UBE	GROL M	D 4410	Туре,	Print) FAL	LS	RO	P	BALT	OM	0 21	211	
	Sta Registi		31. Date filed (Month, Day, Year)	4 2005	gistrar's Signature	B	cons	•							

			For State Registrar	State	of Maryland	-	artment of H		nd Me		iene		
	Physicia		1. Decedent's Name (First, Middle,	Last)	BERE					2. Date of Deat	- /) 05 Vear 05	& Time of Defith?
	/Medic Examin		4a. Facility Name (If not institution, BALTIMORE RE	-			4b. City, Town, or	Location of	Death ALT	MURE	-	nty of Death	10 1511
	Funeral Director		394-28-0232	6. Sex 1 X IM 2□F	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, Dec 8,	Year)	Coul	place (State or Foreign ntry) Consin
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					1	10d. Inside City Limits
	Mary a-f sh	tor	MD			Ba1t	imore						1√ Yes 2 No
	ith the or 284	Director	10e. Street and Number				10f. Zip Code			1	0g. Citizen	of What Cou	ntry?
	s 23a	ral	603 S. Ann St			140.1		1231			14.5	USA	
	ter de r Itam	Funeral	11. Marital Status 1X Never Married 2 Marrie	Armed F			Was Decedent of Hi f Yes, specify Cuba	spanic Origi n, Mexican,	n? (Spec Puerto R	city Yes or No- lican, etc.)		lace - Americ Ilack, White,	
	eal', or	by	3 Widowed 4 Divorced	If Yes, G Year or D	2□No ive Dates: 152-5	4	1□Yes 2∏ No	Specify:			Spe	^{cify:} whi	te
ה ה	72 ho	eted	15. Decedent' (Specify only highest	s Education grade completed)		(Give	dent's Usual Occupa	lurina most	of working	g	16b. Kind of	Business/In	dustry
7	within ene. than '	Completed	Elementary/Secondary (0-12)	College ((1-4or 5+)		DO NOT use retired)			homo	d	
7	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show avant, the Medical Examinar must be notified at	a)	17. Father's Name (First, Middle, L	ast)	0	Cal	penter	18. Mother	's Name	(First, Middle, M			vements
2	utd be Menta Menta Irkad Itic av	To B	Frank Berelc,	Sr			}	Fra	nces	Bernot			
<u>a</u>	2 sho and ? is me		19a. Informant's Name/Relationsh				ng Address (Street a					vn, State, Zip	Code)
ב ת	1 and Health am 27 thar t		VAMC Extended C 20a. Method of Disposition	are	20b. Pla		Loch Rav	en B1	.vd B			2121 on - City or To	
<u> </u>	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 4 ☑ Donation 5 ☐ Other (Sp		Con	netery, crer	natory or other place	9)		1	200. 2004110	ony or re	Swii, State
Dalling	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Itams 23a or 28a-f show any injury or other traumatic avant, the Medical Examinating must be notified at one.		21. Signature of Funeral Service L Ronal d S	icensee	Acctor	St	Name and Address ate Anato 1timore,	omy Bó	ard	655 W.	Balti	more S	Street
			23a. Part 1 Enter the disease, or o shock or heart failure. List of	complications that	caused the death.				1201 ardiac or	respiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	A.	PUTE	MU	n CARI	DIAI	11	IFAR	CTI	011	Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conseque	nce of):		,		7 / //			
		er	Sequentially list conditions, if any, leading to immediate	b. Due to	oras a conseque	nce of):	NSICH						
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events		(0. 00 0 00.0040								
Ď	e exec ian an irial-tr	Еха	resulting in death) Last	Due to	(or as a conseque	nce of):					_		· · · · · ·
00/0	cate be executed physician and the burial-transit	dical		d									
		/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregnanc	y	_				234	Date of delive	201
, DOX	w requires that the death certifi been signed by the attending I should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		birth 2 Fetal d nant at time of dea		Ectopic pregnancy Other (specify)					Month	Day Year
<u>ر</u>	nat the d by the		9 ☐ Unknown Part II. Other significant condition			ing is the w	adarhiaa aayaa ay	on in Don't		22a Did tob	2222 1122 21	antributa to th	he cause of death?
records,	uires t signe	d by	ATRIAL	F-607	TER		idenying cause give	M M P G C 1.			s 2 🗆 No		pably 4 ∑ Unknown
5	law req as beer 2 shou	Completed	DEPRES	SION	`					24a. Was a		b. Were auto	ppsy findings available
ב	sician: The lav certificate has rector, page 2	Som								autops perform	y ned? ∑No	prior to condeath?	mpletion of cause of 2□ No
VII	cian: ertific ector,	Be (25. Was case referred to medical examiner?	Manadali					of Death	(Check only on			
5	Physi this cral din	1.	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 🗆	7.1	VOutpatien 8b. Time of	t 3 DOA Othe	4A INUIS	-	e 5 🗌 Reside			'y)
VISIO	nding tth. :: After e fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investig	(Mor	nth, Day Year)	Injury	Work	? ′es 2 ∐ N		30. 2000.100 110	w anjury coo	direc	
DIVIS	of or Attal	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	200. Flat	e of Injury - At hom ling, etc. (Specify)	e, farm, str	eet, factory, office		28	8f. Location (St. City or Town		mber or Rura	al Route Number,
	To the Hospital or Attanding Physician: The law requires that the death certifi within 24 hours after death. within 24 hours after death. to tha Funarial Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical C	29a. Certifier (Check only one) 1 Certifying 2 Medical E	xaminer: On the b	e best of my knowled basis of examination	edge, death n and/or in	occurred at the time restigation, in my op	e, date and inion, death	place, ar	nd due to the ca d at the time, da	ause(s) and ate and plac	manner as si e, and due to	tated. o the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	9/45	0		29c. License		_		-	ned (Month,	
			Shen &	Has	hme !	UD	024	64	8	0	7-26	1-20	705
		18	30. Name and address of person v	no completed cau	se of death (Item 2	(Type,	Print) AVEN BL	NO X	BAL	TIMOR	REM.	0 2	1218
	Sta	te	31. Date filed (Month, Pay, Year)	2005	Registrar's Signatu	re de	udi)						
	Registr	ar	TOTAL		THE A.	Jan Bar							

State of Maryland / Department of Health and Mental Hygiene

					war y larro		rtificate of	Death	nornar riy	Reg. N		n c	05101
П	> *Physicia	_	1. Decedent's Name (First, Middle,	Last)					2. Dete of De		av	Year	Time of Death L
1	/Medica		Elizabeth		Campuz	zano			July 1	19,	2005	roai	10:40 PM
	Examine	er	4e Fecility Name (If not institution, Keswick Multica	give street end number re ·Center	er)			4b. City, Town, or L Baltimore		h 4	c. County o	of Death	
	Funeral Director		494-14-1709	6. Sex 7. 1 M 2 F	Age (In yrs. Ia 96	st birthday Yrs.	Months Days		8. Date of Bir (Month, Da Dec. 1	th 1 <i>y</i> , <i>Yee</i> , 19	808	9. Birthp Coun Kans	ace (State or Foreign (ry) 33.S
	pue *		Usuel Residence of Decedent 10a. Stete 10b. County		10c. City,	Town or L	ocation					10	Od. Inside City Limits
	Sa-f sho	Director	MD		Ва	altim							1 Yes 2 No
	ath with the 23a or 2 sunt be n	ral Dire	10e. Street end Number 700 W. 40th Str	eet			10f. Zip Code 21211			U	itizen of WI JSA	hat Coun	try?
020	ors of	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☒ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Tes 2 If Yes, Give Yeer or Dete	s? ŽiNo		Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Sp ean, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.))-	14. Race Black Specify:	- America , White, e	etc.
2-0	n 72 hours natural	2	15. Decedent's (Specify only highest			16a. Dece	dent's Usual Occu	pation during most of worked)	rina	16b. I	Kind of Bus	iness/Ind	ustry
2121	within ene.	Completed	Elementary/Secondary (0-12)	College (1-4d	or 5+)		fessor	d)	ang.	Un	ivers	rity	
ğ	e filed el Hygi other vent, t		17. Fether's Name (First, Middle, La					18. Mother's Nam	e (First, Middle				
<u>a</u>	2 should be end Mentel is merked o	lo Be	James R. Pound,	Jr.				Mattie	Enz				
ary	should mand market		19a. Informant's Name/Relationshi	p (Type, Print)		19b. Maili	ng Address (Stree	and Number or Run	el Route Numb	er, City	or Town, S	itate, Zip	Code)
Σ			Diana C. Schram	n (Daught	er)	501	2 Boxhill	Lane Ba	ltimore	, M	D 212	10	
Baltimore, Maryland 21215-0020	S to the		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		te cen	netery, cre	osition <i>(Name of</i> matory or other pla itan Cren		Date 7/22/05		ocation - C	_	
Balt	permit. Page Depertment of important: If any injury or once.		21. Signature of Funeral Service D	censee	00		Name and Addr Funeral I 7080 Stat	ess of Facility Pepot ee Road 84	Davie	., F	'lorid	a 33	317
	*		23a. Part1. Enter the disease, or connect, or heart failure. List or	omplications that caus	sed the death.								Approximate Interval Between
1	Physician /Medical Examiner	ŀ	Immediate Cause (Final disease or condition)eme	4						1	Onset and Death
		ē	resulting in death)	a	Due to (or a	as a conse	quence of):	\ \					J
6	iceta be executed physician and stha buriel-trensit	Examiner	Sequentially flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	Due to (cr a	is a conset	quence of).			***			
x 68760,	a a	Medical	Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or a	s a consec	juence of):					!	
Вох	ath catternation at the ca			- 3.									
д. О	the de	A SEC	Part II. Other significent conditions	contributing to death	but not resulti	ng in the u	nderlying cause given	en in Part I.	23b. Did	obacc	use contr	ribute to	the cause of death?
s, P.	gned by	Dy rillysician	gastro in tod	tinal Bl	elder	ig,	weig	hTloss	10	Yes	2 No 3	Prob	ably 4 ☐ Unknown
or Vital Records,	The law requires thet the death ce set be seen signed by the attendity page 2 should be deteched for use	balaid			C	/			24a. Was perfo	an auto	ppsy	con	e autopsy findings lable prior to pletion of cause eath?
Ï	The L	5							101	es 2	No	1 🗆	Yes 2□ No
<u>=</u>	ysician: The ysician in the second director, pag		25. Was case referred to medical examiner?					26. Place of Death	n <i>(Check only</i> o	ne)			
>	5 00	2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpa	tient 2 EF	VOutpatier		4) Nursing Ho	me 5 Resid	lence	6 □Other	(Specify)	
onoi	or Attending Pi efter deeth. Director: After th Jin by the funera		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accidentinvestigat	tion	njury Day Year)	8b. Time of Injury	Wo	yat k? Yes 2 □ No	28d. Describe I				
$\dot{\bar{z}}$	tal or Attending P rs efter deeth. al Director: Aftar t led in by the funera		3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	ad 286. Place of I	Injury - At home etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (5 City or Tow			or Rurel	Route Number,
	To the Hospital or Attending Phy within 24 hours effer deeth. To the Funeral Director: Aftar thi completely filled in by the funeral		29a. Certifier (Check only one) Certifying 1 Medicat Ex	Physician: To the best taminer: On the basis end manner:	of examination	edge, death n end/or in	n occurred at the tirvestigation, in my o	me, date and place, a pinion, death occurr	and due to the e	ause(s date an	and manr d place, an	ner as sta d due to	ted. he cause(s)
	To th To th comp	-	29b. Signature and title of certifier	1 ~	2		29c. Licens	e number		29d. Da	ite signed (Month, D	ay, Year)
	7		A fresh	ny Kel	ey, n	10	02	2300		Jul	720	1200	5
	σ		30. Name end address of person wh	GAMIC Y	death (Item 2	3e) (Type, V. Ch	Print) st.	Ealto. a	nd 21:	204	-		
	State Registrar	5	31. Dete filed (Month, Day, Year)	32 Regis	strer's Signatur	· Age	ule						

Cooper, Morrin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend Item 4a per fh G846 8-4-05 that are of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 530 AM COODER Marvin 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. NA 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 12M 2DF 814-58-7252 Director 16. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Instit if item 27 is marked other than "neturel; or items 23s or 28s-1 show may or other transmit or high items and item in the Mindial Experiment and item netities at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 Yes 2 No NIA Baltimore Completed by Funeral Director MO 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21225 Rd USA 825 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced ear or Dates: 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housing Tath Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dorethea Howard 00000 ၉ 19a. Informant's Name/Rela ionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt Balta mo 1006 inthia 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Method of Disposition 1, Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Zion Cemetery Lansdowne, mo 4 Donation 5 Other (Specify) 21. Signature Juneral Service Licens Name and Approximate Interval Between Onset and Death 23a. Party Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or near failure. List only one cause on each line. Immediate cause (Final disease or condition resulting in death) **Physician** ANCEY /Medical Due to (or as a Examiner netactati Esquentially fet sonotions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ō Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, page 2 should be Presmoni 1 ☐ Yes 2 ☐ No 3 robably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2 No certificate 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 1 ☐ Yes 2 No 3 DOA 4₺Nursing Home 5☐ Residence 6 ☐Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 2 Accident 2 No within 24 hours after death. investigation 1 Yes filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WD ess of person who completed cause of death (Item 23a) (Type, Print) (de) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

	1	For Stete Registrar		larylan		artment of H	ealth and N	Mental Hygie		
Physiciai /Medica Examine	in al	1. Decedent's Name (First, Middle, La Baby Boy Coat 4a. Facility Name (If not institution, give	es	1//	2	4b. City, Town, or	Location of Death	2. Date of Death Month July	1 :	ear 3. Time of Death ear 1005 11: 7/ 4-1 Death
Funeral Director			-		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min. 29	8. Date of Birth (Morph, Day,) July 2,	^{'ear)} 2005	n. Birthplace (State or Foreig Country) Maryland
the Marylan 28a-f show coliffical at	ctor	MD 10b. County MD 10e. Street and Number		10c. City	Balti					10d. Inside City Limit
urs after death v al', or Items 236 grander must	by Funeral	2624 Matthews St 11. Marital Status 1X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Tyes 22 If Yes, Give Year or Dates:	? No	1:	Vas Decedent of His Yes, specify Cubar				American Indian, White, etc. black
be filed within 72 ho hall Hygiene. od other than "netur evant, Ib Wedfeal		15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) **Right	ade co <i>mpleted)</i> College (1-4or Lone	5+)	(Give	ent's Usual Occupa kind of work done d DO NOT use retired)	uring most of work	ing 16		ness/industry
1 and 2 should be Health and Mental sam 27 Is marked of other traumatic ev	0	Neil Johnson Jr ^{19a.} Informant's Name/Relationship <i>(</i> Johns Hopkins H	Type, Print)				nd Number or Rura	a Coates al Route Number, C ltimore,		
permit. Pages 1 a Department of Hes Important: If itam any injury or othe once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ∰ Other (Specifications) of Funeral Solvice Licer **Ron. 1 d S.**	y) in state		emetery, crem	nation (Name of latory or other place Name and Address ate Anato	s of Facility	Date 20.		y or Town, State
physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician physic	lical Examiner	And Lenter the disease, or come shock or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as Due to (or as d.	a consequ	ence of):	1timore, ir the mode of dying				Approximate Interval Between Onset and Death 7.7.
death certif e attending d for use a	Iyaiciaii/Me	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3□	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
engi be od	בר בר בר בר בר בר בר בר בר בר בר בר בר ב	art II. Other significant conditions c	ontributing to death b	ut not resu	lting in the un	derlying cause giver	n in Part I.	23e. Did tobac		te to the cause of death? Probably 4 □Unknov
ate h		E Was and the state of the stat						24a. Was an autopsy performed 1 Yes 2	prior deat	e autopsy findings availab to completion of cause of h? Yes 2 \(\sumbole\) No
after death. Director: After this certific it in by the funeral director, erification: To Be C		15. Was case referred to medical examiner? 1		ry :	PVOutpatient 28b. Time of Injury	3 □ DOA Other 28c. Injury a Work?	at 2	(Check only one) ne 5 Residence 28d. Describe how in		Specify)
ral Dir led in Cert) <u> </u>	3 Suicide 6 Could not be determined	building, et	c. (Specify)	ledge death	occurred at the time	data and place of	City or Town, Si	ta te)	r Rural Route Number,
within 24 hours to the Funa completely file	2	9b. Signature and title of certifier Value Gon	and manner sta	ated.	on and/or inve	29c. License	number	d at the time, date	and place, and	onth, Day, Year)
State		O. Name and address of person who of John Hople (1) 1. Date filed (Month, Day Year)	Hospitel	eath (Item :	ON.	wolfe	St. P.	Tones Intimore	MD	21287

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Hinh DAV15 2005 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month Day) JOHN HOPKIN 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 F NONE Yrs. Director mak 10lic Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Mudical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director MARYLAN de 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 deeth with WILLIAMS or Items 23a 10 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 is marked other then "natural", or ite 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes → No Specify. Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NFAIU 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MILO ပ MAL AUNAVAN MYNU N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HAURT del PARCE AWNAVAN ANI E 00 1161 Prive or other 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or 21078 `4□Donation 5☒Other(Specify) in state 21. Signatur of Euneral Service Licensee Ronald S. Wade, 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician ba /Medical Due to (or as a consequence of) Examiner Tremt Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be execuled burial-trarisit mature Due to (or as a consequence of): Be Completed by Physiclan/Medical Tre mature detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? director, page 2 should be 3 Probably 4 Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Alatural 5 Pending Injury death. investigation 1 Yes 2 No 2 Accident after death Diractor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours To the Funeral 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 i Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) completely 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 Protessi P005430 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Ave Baltimore Mi) EDWARD E. LANGEN 3. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar AUG 0 4 2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Elsenmeier **Physician** Month Edmund 7.35 PM \circ 07 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1801 Wentworth Rd Barround 21234 Backlo Batto Co const If Under 1 Year | If Under 24 Hrs. | 8 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1**X**M 2□F Director 20018 6708 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits other traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2√2 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8622 Richmond Avenue 21234 or Items 23e USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if tem 27 is marked other than "naturel", or fler any injury or other traumatic event, the Medical Examina 2008. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk unk (Specify only highest grade completed) Elementary/Secondary (0-12) Colfege (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph H. Eisenmeier Hedwig Koessel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Eisenmeier/son 8601 Richmond Circle Baltimore, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade, Director 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street mun Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Due to (or as a consequence of): **Physician** resulting in death) /Medical Examiner Cescoro vamlen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine certificate be executed burial-transit Accident with Right eaphral Vasan resulting in death) Last Due to (or as a consequence of): the attending physicien P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death Month Dav Year 5 Other (specify) 9 🗆 Unknown ል signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an performed? Post 1 Yes 2 19 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b Time of 28c. injury at Work? 28d. Describe how injury occurred 1 THatural 5 Pending within 24 hours after death. To the Funerel Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7/26/05 D31464 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HASHMI MD, 821 N. EUTAN ST fante 308, Ballimine MD 32. Registrar's Strature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death FLOOD **Physician** ETEK JULY 2005 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** I UNSON
If Under 24 Hrs. JOSEPH CENTEX 6. Sex 1 M 2 F 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Days 216.16.850 Director VIRGINIA Usual Residence of Dece 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-1 show the Medical Exeminer must be notified at 1 Yes 2 No MD BACTIMORE Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Funeral , or Itams Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces: 1 □ Yes 2 □ No filed withIn 72 hours after 1 ☐ Never Married 2 Marned BLACK Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, If a Medic once. Elementary/Secondary (0-12) College (1-4or 5+) LABORER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname. IOHN ATTERSON 19b. Mailing Address (Street and Number or Rural Route Number, City RCLE KANDAUSTOWN, MD 21133 bb. Place of Disposition (Name of crematory or other place) 20a. Method of Disposition
1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee VAUGHN C. GREENE FUNERALIM BACTIMORE, MARNAND 21212 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Preumonen Days /Medical Due to (or as a consequence of) Examiner ymphount. Leuken Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence o Examiner attending physician and for use as the burial-transit be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical use as I IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year Day 4□Pregnant at time of death signed by the at d be detached fo 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ JUNK OWN 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 200 Hospital: Other: 2 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27 Manner of Peath 28a. In te of Injury 28h Time of 28d. Describe how injury occurred Certification: After National 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To tha Funeral Director: 6 Could not be determined 3 🗀 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Testifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DO05942 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mildi Ferusera 31. Date filed (Month, Day, Year) Good Samertan Brot. Bulde

DHMH 17 Rev 1/2001

Registrar

32. Registrar's Signature

AUG 0 4 2005

		-	For State Registrar	State of Mary	•	artment of H			ne No2005	25441
	Physici		1. Decedent's Name (First, Middle, Las	st)				2. Date of Death Month	Day Year 28, 2005	3. Time of Death
	/Medic Examin	al -	Charles Emory I 4a. Facility Name (If not institution, give Saint Joseph I	street and number)	nter	4b. City, Town, or	Location of Death		4c. County of Death	
	Funeral Director		5. Social Security Number 6. S 214-12-0267	ex 7. Age (In	yrs. last birthday, Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	sar) Col	nplace (State or Foreign untry)
bue	3		Usual Residence of Decedent 10a. State 10b. County	10	c. City. Town or L	ocation				10d. Inside City Limits
Mary	1 sh	ţō	MD Baltimo	re	Baldwir	1				1 ☐ Yes 2 No
th the	or 28e	Director	10e. Street and Number			10f. Zip Code	•	10g.	Citizen of What Cor	untry?
tte.	8 238 Mat k	ral	13608 Alliston D		- i- 110		1013		USA	inan Indian
d 21215-0036	Capatrion of Health and Mental Highene. Importent if Item 27 is marked other than "naturel", or Items 23e or 28e-1 show any injury or other treumatic event, in a Medical Examination and injury or other treumatic event, in a Medical Examination and injury or other treumatic event, in a Medical Examination and injury or other treumatic event, in a Medical Examination and injury or other treumatic event, in a Medical Examination and injury or other treumatic event, in a Medical Examination and injury or other treumatic event, in a Medical Examination and injury or other treumatic event, in a Medical Examination and injury or other treumatic event, in a Medical Examination and injury or other treumatic event, in a Medical Examination and injury or other treumatic event, in a Medical Examination and injury or other treumatic event, in a Medical Examination and injury or other treumatic event, in a Medical Examination and injury or other treumatic event, in a Medical Examination and injury or other treumatic event, in a Medical Examination and injury or other treumatic event, in a Medical Examination and injury or other treumatic event, in a Medical Examination and injury or other treumatic event, in a Medical Examination and injury or other treumatic events.	Completed by Funeral	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	rin 0.5.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	Rican, etc.)	14. Race - Amer Black, White Specify: wh	, etc.
Maryland 21215-0036	ne. nan "natur e Medical	npleted	15. Decedent's E (Specify only highest gra		(Give	edent's Usual Occup e kind of work done o DO NOT use retired	during most of worl	king 16	b. Kind of Business/l	
421	Hygier ther ti	Ö	12 17. Father's Name (First, Middle, Last,	2	Buil	der	18. Mother's Nam	ne (First, Middle, Mai	Construc	tion
	hental rked o	To Be	Charles E. Franc				Anna I		,	
lary	is ma		19a. Informant's Name/Relationship (**		,		ral Route Number, C		ip Code)
e, 7	Health em 27 ther tr	ŀ	Blanche J. France 20a. Method of Disposition		1 3 b U			aldwin, M	D 21013 c. Location - City or 1	Town. State
mor	ent of mt: #f !t		1 ☑ Burier 2 ☐ Cremation 3 ☐ 4 ☐ Conation 5 ☐ Other (Specif		•	matory`or other plac Ridge Cer			Pikesville,	
Baltimore,	epart Importe any inju		2) Signature of Fundrich San co Licer		2	2 Name and Addre	es of Facility	ome of Du Timoniu		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.						Approximate Interval Between
,	hysician		Immediate Cause (Final disease or condition resulting in death)	a SEPTIC S						Onset and Death
	/Medical xaminer		1 Country in addition	Due to (or as a co						
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a co						
V 3	physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. STRANGUL Due to (or as a co		ERNIA				
8760,	siclan a		, sasting in oddin, Edot	Due to (or as a co	onsequence or):					
687	g physas the	edical		_ d						
.O. Box 68760, ~	the attending positions as the design of the	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify) _	′		23d. Date of deli Month	very Day Year
a 3	E Ped	b b	Part II. Other significant conditions of	contributing to death but n	ot resulting in the	underlying cause giv	en in Part I.	23e. Did tobad	cco use contribute to	the cause of death?
Division of Vital Records,	has b	Completed						24a. Was an autopsy performe	prior to d	topsy findings available completion of cause of
/ital	is certificate director, pag	BeC	25. Was case referred to medical examiner?					th (Check only one)		
of Vita	S E	ပ္	1 ☐ Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatie		4 Iduising in	ome 5 Residence		cify)
On	After	tlon	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Mete of Injury (Month, Day Ye	28b. Time (lnjury	Wor	yat rk? Yes 2∐No	28d. Describe how	injury occurred	
Division	i Si je e	Certification:	3 Suicide 6 Could not be determined	e 29a Blace of Injune	- At home, farm, s Specify)	treet, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
3	within 24 hours after of To the Funerel Direct completely filled in by	edical C	29a. Certifier 1 Certifying PI (Check only one) 1 Medical Example 1 Certifying PI	nysician: To the best of m miner: On the basis of ex and manner stated	amination and/or i	th occurred at the tir nvestigation, in my o	me, date and place opinion, death occu	, and due to the caus rred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
,	withi To th	Ě	29b. Signature and title of certifier			29c. Licens	se number		Date signed (Month	
)			Jun	2	CE	D 30	263		07-28-	05
	4		30. Name and address of person who				(100 June 5 1 2 1 20 mm	V/1 /03-199 - :	2004 a 2004 a 2	
	St	ate	31. Date filed (Month Aug Gar)	32. Rastrar's		VIVE TOW	SUN MAR	YLAND 21	2/04	
	Regist	rar	1100 0 4	LUUJ ACTOR	B. A	CONT.				

			1 - For State Registrar	State of N	Marylan		artmen rtificat			and M	-	giene Reg. No	200	-	251112
	Physici	an	1. Decedent's Name (First, Middle, La: Louise Victoria	•							2. Date of De Month July 2		2005 Yes	ar	3. Time of Death 3:16 A M
	/Medio Examin	- 41	4a. Facility Name (If not institution, give Anne Arundel Med	e street and number			1	Town, or	Location o	of Death	oury 2		County of D		
	- Funeral Director		219-10-9013	өх □ м 2 ХСХ F	Age (In yrs. 82	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir Month, Da June 29	th y, Year) 192	23 M	Birthpla Country D	ce (State or Foreign y)
	filed within 72 hours after death with the Maryland Hygiene uther than "natural; or itams 23e or 28e-f show ant, the Medical Exame ar must be calified at	ctor	Usual Residence of Decedent 10a. State 10b. County MD Anne An	runde1	10c. Cit	y, Town or Lo	ocation							100	d. Inside City Limits
	with the	Director	10e. Street and Number				10f. Zip					10g. Citi	zen of What		y?
	itams 23	by Funerai	42 Mansion Road 11. Marital Status 1 □ Never Married 2 ☒ Married	12. Was Decede Armed Force 1 \(\text{Yes} \) 2[s?	.S. 13.	Was Dece	1090 dent of Hi cify Cuba	spanic Ori n, Mexicar	gin? (Sp	ecify Yes or No Rican, etc.))-	U.S.A 14. Race - A Black, W	mericar	
-0036	hours af	ed by F	3 Widowed 4 Divorced	If Yes, Give Year or Date			1 ☐ Yes		Specify:			16b. Ki	Specify:		nite
21215-0036	d within 72 jene. r than "na the Media	Completed	(Specify only highest graves (0-12) 12	College (1-4c	or 5+)	(Give	kind of wo DO NOT u emake	rk done d se retired	<i>during</i> mos	t of work	ing		Own H		•,
Baltimore, Maryland	permit Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23s or 28s-f show may in urry or other treumatic event, the Medical Exprising must be multiled at 2008.	To Be C	17. Father's Name (First, Middle, Last) Walter Simon								e (First, Middle) a Gac	, Maiden	Sumame)		
Man	Ith and 257 is my		19a. Informant's Name/Relationship (Mrs. Susan Gallag		hter		_				al Route Numb everna	-			
nore,	ages 1 ar ant of Hea it: if itam y or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from Sta	20b. F	Place of Disponentery, crei	osition (Nar matory or o	ne of other plac	e)	(Date	20c. Lo	Burn:	or Tow	n, State
Baltir	permit P Departme Importen eny in ur		21. Signature of Fundamental Service Licer		13/9	22	2. Name ar	nd Addres	s of Facili	y Si	ngleton ., Glen	Fur	eral 1	Home	P.A.
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that cause one cause on each	sed the deat hine.	Λ	ter the mod	de of dyin	g, such as		5	rrest,		J	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions, if any, leading to immediate	b. ldy	as a consecutive few	win		0						7	nimilis
8760,	cate be executed physician and the burial-transit	ical Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	· Smi	as a consection as a consection	mwel	ohst	niet	ton u	rith	e ische	mil	collt	11 (lays
O. Box 6	death certifi e attending id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 10 9 ☐ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnan 9 □ Unknown	2 ☐ Feta tat time of c	al death 3	⊒Ectopic pi ⊒ Other (sp						23d. Date of Month		/ Pay Year
rds, P.	quires thai in signed I uld be det	þ	Part II. Other significant conditions of	contributing to deat	but not res	sulting in the u	inderlying o	ause give	en in Part I			tobacco t Yes 2		e to the	cause of death?
Division of Vital Records,	: The law requires that the cate has been signed by th pege 2 should be detache	Completed	COPI)										24b. Were prior death	to com	sy findings available pletion of cause of
/ital		Be	25. Was case referred to medical examiner?					10.	-		h (Check only o	one)			
n of \	ing Physi After this c uneral dire	on; To	1 Yes 2 No 27 Manner of Death Natural 5 Pending	28a. Date of J (Month,		ER/Outpatie 28b. Time o Injury	of 2	28c. Injun Worl	y at k?		ome 5 Resi 28d. Describe			Specify)	
Divisio	or Attending after death. Director: After in by the fune	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of	Injury - At h	ome, farm, st	M reet, factor		Yes 2 🗌	No	28f. Location (City or To	Street an wn, State	d Number of	Rural	Route Number,
_	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edicai Ce	29a. Certifier Certifying Pl (Check only 2 Medical Examone)	nysician: To the be miner: On the basi and manner	s of examina	owledge, deat ation and/or in	th occurred	at the tin	ne, date ar pinion, dea	nd place, ith occur	and due to the red at the time,	cause(s) date and	and manner place, and	as stat	ted. he cause(s)
)	To the within To the compl	Me	29b. Signature and title of certifier	Mr	MD				9 number			29d. Da	te signed, (M	onth, D.	ay, Year)
	27		30. Name and address of person who	completed cause of	of death (Ite	m 23a) (Type		-		an,	Anna	york	1 7 Mr.	, 2	140
- 13	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	2005 ^{32. R}	istrar's Sign	ature	Cost	,				./			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 5 35 FM Larre John August 2005 Facility Name (If not institution, give street and number) 4c. County of Death Birthplace (State or Foreign Source) Months Days Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married Married 1 Yes 2 No 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry condary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License En er the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Alken Sclew Due to (or sa a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 242 No 26. Place of eath Check only one Hospital:

Physician /Medical Examiner Box 68760, Completed by Physician/Medical Division of Vital Records, P.O. within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be Certification: To

Physician

/Medical

Examiner

Funeral

Director

other traumatic event, the Medical Examiner must be notified at

5

"natural',

permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "nat any injury or other traumatic event, the Medica once.

Baltimore, Maryland 21215-0036

Be Completed by Funeral Director

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner?

1 Yes 2 No Other: 1 Inpatient 3 DOA 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined

Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

306L

2005 Baltime Maylore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Back River Sabapalhi 201-109

31. Date filed (Month, Day, Year) AUG 0 4 2005

29b. Signature and title of certifier

3 ☐ Suicide 4 ☐ Homicide

29a. Certifier

Medical

State

Registrar

. Registrar's Signature

			For State	State of Maryland / Department		Mental Hygie	ne	
			Registrar 1. Decedent's Name (First, Middle, Last)	0 11	rtificate of Death	Reg. 2. Date of Death	No.2005	3Time of Death
	Physici /Medic	_	Nathaniel F.	Gulliver		August	2, 2005	5 9:15 PM
	Examin	er	4a. Facility Name (If not institution, give s	110 0	4b. City, Town, or Location of Death Baltimore		4c. County of Oeal	th
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs last/birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Bir	thplace (State or Foreign
	Director		306-09-9606 19 Usual Residence of Decedent	M 2□F 94 Yrs.	Months Days Hours Min.	January	1,1911 ma	iryland
	nyland how		10a. State 10b. County	10c. City, Town or Lo				10d. Inside City Limits
	he Ma 28a-f s	Director	mo Baltimo	ore Towson		1		1 Yes 2 No
	3a or	i Dir	115 E. Melrose	Ave.	10f. Zip Code 2/2/2		Citizen of What Co	ountry?
	ter deat	Funeral	11. Marital Status	Armed Forces?	Was Decedent of Hispanic Origin? (SI If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ame Black, Whit	
980	72 hours after death with the Maryland natural; or Items 23a or 28a-f show disal Examiner must be motilled at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: B	lack
21215-0036	be filed within 72 hours after death with the Marylan ital Hygiene. ad other than "natural", or Items 23a or 28a-f show ad other than "natural", or Items 23a or 28a-f show avent, the Madical Examinat must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	completed) (Give	dent's Usual Occupation kind of work done during most of won	king 16t	. Kind of Business/	/Industry
121	within iene.	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)	S	teel mi	11
	be filed tal Hygie d other avent, II	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Nam	ne (First, Middle, Mai		
Maryland	Mer	ပ္	199. Informant's Name/Relationship (Tyx)	R Print) 19h Maili	ing Address (Street and Number or Ru	Smith	to as Town State	Zi- Code)
Ma	12 s h an 7 ls trau		Ruth Young - E	SISTER 360	O W Franklin S	t. Apt. B	B BALTO.	mo 2/229
Baltimore ,	Pages 1 and nent of Healt int: If Item 2 iry or other		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re		matory or other place)	1.0	Location - City or	
İtim			4 □ Donation 5 □ Other (Specify)21. Signature of funeral Service License	bayview	Crematory 19-3. 2. Name and Address of Facility —	9 1	indalk, n	10
Ba	permit. Departri Importe any init		Sant 1 Man	8	gry P. March Fu 70 Freuhilton Pas	neral Horis Balto.	ne P.A. MD 213	129
			snock, or near failure. List only on	cations that caused the death. Do not en re cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
*	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Oue to (or as a consequence of):	metice Lung I) were		Cokoun
П	Examiner		Sequentially list conditions, b	Conjective h	ear fribe			Unkara
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
o,	cate be executed bhysician and the burial-transit		that initiated events cresulting in death) Last	Due to (or as a consequence of):				Unknown.
928	icate be executed physician and s the burial-transit	dical		l				
Вох 6	eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregnancy			23d. Date of del	ivery
Ю. В	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		_Ectopic pregnancy ☐ Other (specify)		Month	Day Year
Δ.	that th			ntributing to death but not resulting in the u	undertying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of de /?
rds	w requires been sign should be	ed b	Atrial Fibr	illetu.		1 ☐ Yes	2 □ No 3 □ Pr	obably 4 🔽 nknown
Vital Records,	e law re has be je 2 sh	Completed by	Cercorouse	der Accident		24a. Was an autopsy	24b. Were at prior to	utopsy findings available completion of cause of
talF	an: The tificate ha	a	25. Was case referred to medical		26 Plans of Dea	performed 1 Yes 2 2 th (Check only one)	No 1 ☐ Yes	2 No
of Vi	Physician: rthis certificaral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 Inpatient 2 ER/Outpatien	nt 3□ DOA Other: 4 Nursing H	ome 5 Residence	6 Other (Spe	cify)
ou o	fter	tlon:	27. Many of of Death 1 V Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how i	njury occurred	
Division	r Attandi er death. rector: A by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)		28f. Location (Stree City or Town, S	t and Number or Ru	ural Route Number,
Ō	pital or ours aft aral Di		29a. Certifier 1 Certifying Phys	100				
	To the Hospital or Attanding within 24 hours after death. To tha Funaral Director: After completely filled in by the fune.	Medical	(Check only one)	sician: To the best of my knowledge, deat ner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	, and due to the cause rred at the time, date	 (s) and manner as and place, and due 	s stated. to the cause(s)
	To the within To the comp	Ĭ	29b. Signature and title of certifier	7	29c. License number		Date signed (Monte	h, Day, Year)
,	11/		30. Name and address of person who as	empleted cause of death (Item 23a) (Type,	D0259056	-	2/2/02	
	5		Dalicet Salvia	MO 1600 W		tue Ball	MO 2	1217
	Sta Registi		31. Date filed (Month, Day, Ye	0 4 20 Registrar's gnature	4 Corelle			

			For State Registrar	State of Maryla	nd / Depa	artme	nt of H			l Hygie	•	oie.	
	Physici		Decedent's Name (First, Middle, Last) John Darrington							of Death	Day 2, 21	105 185	3. Zime t beats 5
	/Medio Examin		4a. Facility Name (If not institution, give s Saint Joseph M		ter	4b. City	, Town, or	Location of D	Death ISON		4c. County	of Death	imore
	Funeral Director		5. Social Security Number 6. Sec 426-36-9967 1 Usual Residence of Decedent	7. Age (In yr	s. last birthday) Yrs.	If Und Months	or 1 Year Days	If Under 24 Hours	Min. (Moi	of Birth nth, Day, Yo	ear) 1929	COU	place (State or Foreign ntry) issippi
	he Maryland 28a-f show otitled at	Director	10a. State 10b. County MD Baltimore		City, Town or Lo	ım							10d. Inside City Limits 1 ☐ Yes 2 M No
9800	72 hours after death with the Maryland Inatural; or Itema 23a or 28a-f show dical Examinar nual be notified at	by Funeral	10e. Street and Number 12101 Tullamore C 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Stes S No If Yes, Give Year or Dates:					n? (Specify Yes Puerto Rican, e			e - Ameri k, White,	can Indian,
215-0	high and a sign	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)			kind of w DO NOT	ork done d use retired	during most of)	f working	16	b. Kind of Bu	siness/ir	ndustry
Maryland 21215-0036	be filed ital Hygi od other event,	To Be Cor	12 17. Father's Name (First, Middle, Last) John Darrington	Gandy Sr.	Gene	ral M	anag	18. Mother's	Name (First, a	Middle, Ma			Claims
	nd 2 she lith and 27 is m r traum	F	19a. Informant's Name/Relationship (Ty	pe, Print)				and Number	or Rural Route	Number, C	ity or Town,		o Code) D 21093
Baltimore,	Pages 1 are neut of Hearn ant: If itam arry or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Domation 5 □ Other (Specify)	emoval mom State	Place of Dispo cemetery, crea	osition (Na matory or	rne of other plac	e) 8.	-04-d	005 20	c. Location -	City or T	own, State
Balti	permit. Pages Department of Important: If I any injury or once.		Bryan W. Cla	Bel	2:	2. Name a	nd Addres	s of Facility					ey, Inc.
	Fnysician		23a. Part1. Enter the disease, or composhock, or heart failure. List only of Immediate Cause Final disease or an into	cations that caused the de te cause on each line.	ath. Do not en	ter the mo							Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions.	Due to (or as a cons	ERIOR	MYD	CARD	IAL I	NEARCT	TION			
68760,	be executed sicien and burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons									
.O. Box 687	at the death certificate be executed by the attending physicien and tached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) 8 \(\text{Unknown} \)	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3	□Ectopic	pregnancy				23d. Date Mor		ery Day Year
٥.	ires tha signed d be de	by	Part II. Other significant conditions cor PULMONARY HEMORRH	_	esulting in the u	ınderlying	cause give	en in Part I.	236	Did tobac	13.00%		he cause of death?
Il Records,		Completed								u. Was an autopsy performe Yes 2	d? B	Vere autorior to colleath?	opsy findings available impletion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:			Oth	ar.	Death (Check				
of	ing After une	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injun Worl	7 🗆 110131			e 6 ∐Othe		(y)
Division	Z et = C	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al building, etc. (Spe	home, farm, st	reet, facto	ry, office			ation (Stree or Town, S		er or Run	al Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, deat nation and/or in	th occurre vestigation	d at the tin	ne, date and pointon, death	place, and due occurred at the	to the caus time, date	se(s) and ma and place, a	nner as s ind due t	stated. o the cause(s)
)	within To #	M	29b. Signature and title of certifier	ou Mi D.			D 24	number Ø34		29d.	Date signed	OS	Day, Year)
_	19		30. Name and address of person was be TIMOTHY LOW M. D	mpleted cause of death (II			TOWS	ON MA	RYLANI	218	204		
	Sta Registi		31. Date filed (Month, Day, Year) AUG 0 4 2005	32. Registrar's Sig	nature	and a							

DHMH 17 Rev 1/2001

ORIGINAL

	1- For State of Maryland / Depar Registrer Cert.	rtment of Health and Mificate of Death	lental Hygiene	2005 0511
Physicia	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day	Year (3. Jime of Eleati)
/Medica	Willis Har	din	7 31	2005 11:30 PM
Examine		4b. City, Town, or Location of Death		County of Death
	FRANKLIN SQUARE HOSPITAL CENTER	ROSEDALE		BALTIMORE
Funeral	1₹1M 2□ F	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreigr Country)
Director	Usual Residence of Decedent		Sept. 1,19	34 North Carolina
of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23s or 28e-1 show other treumetic event, the Medical Examinat must be notified at	10a. State 10b. County 10c. City, Town or Loca			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
28e-1	Maryland Baltimore 10e. Street and Number	10f. Zip Code	Oundalk	izen of What Country?
10 To 10	1002 G			
18 23	1903 Guyway 11. Marital Status 12. Was Decedent Ever in U.S. 13. W.	21222		ited States 14. Race - American Indian,
or Item	1 □ Never Married 2√€ Married 1 □ Yes 2√€ No	as Decedent ol Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto □ Yes 2⊊No Specify:	Rican, etc.)	Black, White, etc.
ural',	3 Widowed 4 Divorced Year or Dates:			Specify: White
n "nat	(Specify only highest grade completed) (Give ki	nt's Usual Occupation ind of work done during most of worki O NOT use retired)	ng 16b. Ki	nd of Business/Industry
the	Elementary/Secondary (0·12) College (1·4or 5+) 4 Years	Crane Operator		Industrial
othe ent,	p 17. Father's Name (First, Middle, Last) Tinkn -		(First, Middle, Maiden	Sumame)
ked ic ev		Doroth	ny Collins	
mer		Address (Street and Number or Rura	-	r Town, State, Zip Code)
27 lg	Mrs. Rose D. Hardin (Wife) 1903	Guyway Dundalk	Maryland	21222
r othe	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition	ition (Name of Eatory or other place)	Date 20c. Lo	cation - City or Town, State
ant: Il		Service Corp. 8/2,	/2005 To	wson, Maryland
Importent: If item 27 Is eny injury or other tre <u>once.</u>		Name and Address of Facility Ouda-Ruck Funeral 922 Wise Ave. Du	Home of Du	ndalk, Inc.
1	23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death
the bur	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.			
been signed by the attending p should be detached for use as	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E	Ectopic pregnancy Other (specify)		23d. Date ol delivery Month Day Year
igned b	Part II. Other significant conditions contributing to death but not resulting in the unc			use contribute to the cause of death?
plnot	ASPERGILLUS FUMIGATUS, PENICILLIUM	Species	1 🗓 Yes 21	□ No 3 □ Probably 4 □Unknow
age 2 st	ASPERGILLUS FUMIGATUS, PENICILLIUM		24a. Was an autopsy performed?	24b. Were autopsy lindings availab prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
tifica tor, p	p 25. Was case referred to medical	26 Place of Death	1 Yes 2 No	121195 221190
dire	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of	3 DOA Other: 4 Nursing Ho	me 5 Residence	
or: Afte	1 X Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 Yes 2 No	new more and	,
of in by	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, streed building, etc. (Specify)	et, factory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number,)
	29a. Certifier 1 1 Certifying Physician: To the best of my knowledge, death of the control one) 2 Medical Examiner: On the basis of examination and/or investand manner stated.	estigation, in my opinion, death occurr	ed at the time, date and	place, and due to the cause(s)
To th	29b. Signature and title of certifier	29c. License number	29d. Dat	e signed (Month, Day, Year)
	1 4 FP	1200632	16 T.	hy 31 200 (-
6	29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, P Dr. JING TONG 1900 FRATIK LIN SOURK E 31. Date filed (Month, Day Year) 4 2005 32. Resistrar's Signature A	rint)		1 11, 2003
	Dr. JING TONG 4000 FRATIKUM SOURKE	DRIVE, BALTIMO	RE, MD 2	11237
State Registra	AUG 0 4 2005			

JET 05-05077 Unknown JUA

N.	A HAINE	S	For	State of Maryland	/ Department of He		ntal Hygie	ne	
			1 - State Registrar		Certificate of D	Peath	Reg.	No. 000	0 = 1
п	Physici	an	Decedent's Name (First, Middle, L	Ast)		2.	Date of Death Month	Day Year	3 Timeyof Death
	/Media	al	Juan	T, Itai	hes		uly 2	27 2005	8:27 P M
	Examir	er	4a. Facility Name (If not institution, g		4b. City, Town, or t			4c. County of Death	
-	<u> </u>	_	324 E. Lafayette 5. Social Security Number 6.	AVE Sex 7. Age (In yrs. las.	Baltimore (st birthday) If Under 1 Year		Date of Righ	NA	-1. (0 5
	Funeral Director	8	215-86-7203	15 M 2 F	Yrs. Months Days	Hours Min.	Date of Birth (Month, Day, Ye.	ar) Scoul	place (State or Foreign
	N _a e	'	Usual Residence of Decedent)) 1	769 Mar	yluna
	the Marylan 28a-f ehow	_	10a. State 10b. County	10c. City, 1	Town or Location				10d. Inside City Limits
	8a-f	cto	Md Dal	to. Co	Keysville		. <u> </u>		1 Yes 2 No
	with th	౼	10e. Street and Number	C 1 Cys	/ 10f. Zip Code	-	10g.	Citizen of What Cour	
	234	Fal	3 Meadow	Grass Ct.		30		U.S. A	
	after death w or iteme 23a	Funeral Director	11. Marital Status √ Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2. No	13. Was Decedent of His If Yes, specify Cuban,	panic Origin? (Specify , Mexican, Puerto Ric	Yes or No- an, etc.)	14. Race - Americ Black, White,	can Indian, etc.
336	urs af	by	3 Widowed 4 Divorced	If Yes, Give / Year or Dates:	1 ☐ Yes 2 🗖 No	Specify:		Specify: B/a	ck
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23a or 28a-1 show other traumatic event, the Mudical Examiner must be notified at	Completed	15. Decedent's	Education 1	16a. Decedent's Usual Occupati	ion	16b	. Kind of Business/In	dustry
21	within 7 ene. than "r	ple	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done du life. DO NOT use retired)	ring most of working			
21	filed with Hygiene. Ither thai	Con	12	4	Electricia	~		Electri	1c
nd	should be filed within and Mental Hygiene. marked other than matic event, the M	Be	17. Father's Name (First, Middle, Las	t)	1	18. Mother's Name (Fi	irst, Middle, Maid	(en Sumame)	
<u></u>	should be nd Mental I marked o	스	Joseph It	aines		Gladys	Sone	5	
Maryland	2 sho		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Address (Street an	d Number or Rural Ro	oute Number, Cit	y or Town, State, Zip	
	s 1 and if Health item 27 other tr		20a. Method of Disposition	S 20h Bloo	5 18 N. LINU se of Disposition (Name of	100d Ane	· Da	Ito Md.	2/205
Baltimore,	0 0 = =		1 ☐ Burial 2 🔀 Cremation 3	☐Removal from State	etery, crematory or other place)	Date	20c.	Location - City or To	own, State
Ē	permit. Pag Depertment Important: I any Injury o	4	4 □ Donation ' 5 □ Other (Special Signature of Funeral Service Lice		enmount (rema	tory Aug 6	2005	atto u	y
Ba	permit. Depertr Importe any inje		21. Signature of Furieral Bervice Lice	A /	2. Name and Address	1 Douglas	5 Fune	yal serv	ice F.A.
2	* 4		23a. Part1. Enter the disease, or con	nolications that caused the death (Do not enter the mode of drung	-WLOK ST	· Dals	D. M. 2	Approximate
	- 191		shock, or heart failure. List onf Immediate Cause (Final	one cause on each line.	so not onto the mode of dying,	SUCH as cardiac of 19	spiratory arrest,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a Havell	ng				
9	Examiner		ſ	Due to (or as a consequen	ice of):				
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as a consequen	nce of):				
	sicien and burial-transit	Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events						
oʻ	exec en an rial-tr	Exa	resulting in death) Last	Due to (or as a consequen	ce of):				
68760	ficate be executed physicien and s the burial-transit	edlcal		d					
		Med	IF FEMALE:						
Вох	eath certif attending for use as	an/l	23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de				23d. Date of delive	nry
	at the dea by the at tached fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐ Unknown				Month	Day Year
P.0	d by	Physician/M							
ŝ	requires that the death cert een signed by the attendin nould be detached for use a	þ	Part II. Other significant conditions	contributing to death but not resultin	ig in the underlying cause given	in Part I.		use contribute to th	
0	w requir been si should	Completed					1 🗌 Yes	2 No 3 Prob	ably 4 Unknown
360	The law ite has b	dr					24a. Was an autopsy	prior to con	osy findings available inpletion of cause of
a	r: The icate he						performed?		2 No
Division of Vital Records,	Attending Physicien: r death. ector: After this certifica oy the funeral director. p	Be	25. Was case referred to medical examiner?	Hospital:	0.1	6. Place of Death (Ch			
of	Phys ral di	၉	1 V Yes 2 No 27. Manner of Death	1 Inpatient 2 ER/	Outpatient 3 DOA Other.	4 Nuising Home			Scene
O	ding I. h. After funer	tlon	1 Natural 5 Pending	Follow (Month Day Year)	Injury Files Work?	s 2 2 No 280.	Describe how in	lury occurred	-0 5001
isi	i or Attendi after death. Director: A i in by the fu	flca	3 Suicide 6 ☐ Could not I	De 28e Place of Injuny At home	5.731	,		and Number or Rura	
ă	e after after Direction	Certification:	4 Homicide determined	building, etc. (Specify)	Du Odi 40	201.	City or Town, Sta	10) 374 E	Latayetk
			29a. Certifier 1 Certifying P	hysician: To the best of my knowled	dge, death occurred at the time.	date and place, and o	due to the caused	(s) and manner as et	ated.
	he Hu in 24 he Fu pletel	edical	(Check only 2 Medical Exa	miner: On the basis of examination and manner stated.	and/or investigation, in my opin	ion, death occurred at	the time, date a	nd place, and due to	the cause(s)
	To the within 2 To the E complete	Ž	29b. Signature and title of certifier	1 11 1	29c. License n	umber	29d. D	ate signed (Month, L	Day, Year)
	di		Um	11. JA- 4	OCME		Jul	y 28	2005
	1		30. Name and address of person who	completed cause of death (Item 23	(a) (Type Briet)			y	۷00)
	4			N.D. 111 Pe	on St. B	alfo. led	•		
1000	Stat		31. Date filed (Month, Day, Year)	32. Registrar's Signature	v f.v.				
	Registra		AUG 0 4	2005 Alexan	U parce				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month Louise Jackson 30 2005 /Medical 7:00 a4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Balto 7508 Reserve Circle #302 Windsor Mills If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) S.C. **Funeral** Date of Birth (Month, Day, Year) 250-28-2314 1 □ M 2 🛛 F Yrs. Director 11-25-1907 Usual Residence of Decedent the Maryland 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits is 1 end 2 should be filed within 72 hours after death with the Marylar of Heelth and Mental Hygiene. It heelth and Mental Hygiene a few at 12 fe marked of other then "natural", or items 23a or 23a-f ehow other traumatic event, "the Medical Examinat must be notified as other traumatic event," Md Director Balto Windsor Mills 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7508 Reserve Circle # 302 21244 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ۵ 1 Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Specify: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Homes N/A Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walsh Austin Vermell Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jannette Edwards - Granddaughter 7508 Reserve Circle Windsor Mills, Md 21244 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Peges 1
Department of H
Important: If ite
any injury or oth cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 8-4-2005 Balto, Md 21215 21. Signature of Funeral Service Dicense 22. Name and Address of Facility March F/H West Wabash Avenue Balto, Md 21215 4300 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Emer underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner onsequence of certificate be executed use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical the attending phy IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown à Part II_Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Physiclan: 25. Was case referred to medical 26. Place of Death Check onl one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) Certification; 27. Manner of Death 28c. Injury at Work? 28b. Time of After 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation efter death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours e To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Tip Certifying Physician: 10 the dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person WILKENS AVE BALTIMULE, MD2122 3451 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

ORIGINAL

DHMH 17 Rev 1/2001

			For State Registrar	State of M	aryland / Dep <i>Ce</i>	partment of Fertificate of		, 0	ene	E 25110
	Physici		Decedent's Name (First, Middle, L. Je	nnifer Joh	nson			2. Date of Death Month August	Day Y	ear 8:/SAM
	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and number)			r Location of Death Baltimore		4c. County of	Death
	Funeral Director			Sex 7. Ag 1 □ M 2 □ F	ge (In yrs. last birthda 56 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay, Y	^(ear) 1949	Birthplace (State or Foreign Country) Australia
	e Maryland le-f show	ctor	10a. State 10b. County Maryland N/A		10c. City, Town or		Baltimore	2		10d. Inside City Limits 1
	3e or 28	il Dire	10e. Street and Number 3801 Canterbury	Road Unit	618	10f. Zip Code	1218	100	g. Citizen of Wha	at Country? Australia
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23e or 28e-f show says injury or other treumetic event, the Medical Evan mar must be redified at ODGe.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces' 1 Yes, Give X Year or Dates:	Ever in U.S. 13	. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. White
21215-0036	vithin 72 hou ne. hen "natura ie Medical E	Completed	15. Decedent's 8 (Specify only highest g Elementary/Secondary (0-12)	ducation	16a. Dec (Gin life	edent's Usual Dccup re kind of work done DO NOT use retired	during most of work d)	ring	Sb. Kind of Busin	
1 2	e filed v al Hygie I other t vent, L	Be Co	17. Father's Name (First, Middle, Las	t)		ociologist		e (First, Middle, Ma		okins University
Maryland	hould b	ToE	Charles Knott 19a. Informant's Name/Relationship		19h Ma	iling Address (Street	and Number or Rus	Betty Edi		ata Zin Coda)
	and 2 s salth an n 27 Is i		Mary Jane Sundi			Sparks Far		Sparks, M		ste, Zip Code)
Baltimore,	Pages 1 nent of He ent: If iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special Control of			oosition (Name of ematory or other place cematory,	ce)		oc. Location - Cit Baltimo	ore, MD
Balt	permit. Departr Importe eny inj		21. Signature of Funeral Section 1990. Thomas Grego	8		22. Name and Addre Cremation 299 Freder	Society o	of Maryla Baltimo	nd, Inc.	21228
F	Physician `		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition	nplications that cause one cause on each I	d the death. Do not e ine.	nter the mode of dyin	ig, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					1 years
. /	nted insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (or as	tion Pr	Pilmon	:150			3 years
8760,<	cate be executed physician and the burial-transit	dical Exa	that initiated events resulting in death) Last	Due to (or as	a consequence of):	acomon	X 1 1/3			
.O. Box 6	The faw requires that the death certificate be executed tte has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physiclan/Medlo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 (No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death 3	□Ectopic pregnancy □ Other (specify) _	,		23d. Date o	
<u>α</u>	w requires that been signed b should be dete	by	Part II. Other significant conditions	contributing to death t	out not resulting in the	underlying cause giv	en in Part I.	23e. Did toba		ite to the cause of death? ☐ Probably 4 ☐Unknown
Il Records,		Completed						24a. Was an autopsy parforme	prio dea	re autopsy findings available in to completion of cause of th? Yes 2 No
Vital	Physicien: Th r this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpati	ent 2 ☐ ER/Outpati	ent 3 DOA Oth	00	h (Check only one)	ce 6 ∏Other /	(Specify)
o uc	D 0 0		27. Manner of Death 1 Natural 5 Pending 2 Accident investigate	28a. Date of Inju (Month, Da	ury 28b. Time	of 28c. Injur Wor	y at	28d. Describe how		epec.iy)
Division of	or Atten liter deat Director: in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not determine	be 28e. Place of In	jury - At home, farm, s tc. (Specify)		100 2 3.10	28f. Location (Stree City or Town,		or Rural Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dirt completely filled in I	edical (29a. Certifier (Check only one) Certifying P	hysician: To the best miner: On the basis of and manner st	of examination and/or	ath occurred at the tin investigation, in my o	ne, date and place, pinion, death occur	and due to the caused at the time, date	se(s) and manne and place, and	er as stated. I due to the cause(s)
}	To the within 2 To the complet	Me	29b. Signature and title of certifier	3 6. 4 1		29c. Licens		!		Month, Day, Year)
	5		30. Name and addr as of person who	completed cause of	death (Item 23a) (Type	9, Print)	0 11	10/7	D	3,2005
	Sta	tė	31. Date filed (Month, Day, Year)	32. Jegisti	death (Item 23a) (Typi , Winov rar's Signature	made I	ial Hosp	ital, M	V	
1	Registr	ar	AUG 0 4 2	UUS Steel	w D. My					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 20b per fb, 8847 9-8-05 yt

1	Physici		1. Decedent's Name (First, Middle, Last	st)		0/07/	titijsatj _{ili} of			2. Date of De	Reg. No.	2005	3. Time of Pearly ()
1	/Medi		ZEEK	MARCEL		JEWE				JULY 3			3:30 A M
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Examir	er	4a. Facility Name (If not institution, given HARRY S TRUMAN D				4b. City, Town, LARG		ol Death			County of Death	ORGES CO
	Funeral Director		5. Social Security Number 6. S		ge (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birt (Month, Da 06-28-	th y, Year)	9. Birth Cou	place (State or Foreign intry)
	pug *		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loc	eation						10d. Inside City Limits
	Marylan f ehow	ō	MD PG			RESTV							1X Yes 2 □ No
	r 28a	Director	10e. Street and Number				10f. Zip Code				10g. Citiz	zen of What Cou	untry?
	(h wit	aiD	2513 Wintergreer	Ave				20	747			U.S.A.	
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If itam 27 is marked other than "natural, or itema 23s or 28s-f show or other traumatic event, the Madical Exercise must be collised at	by Funeral	11. Marital Status X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 Tyes 2 Till Yes, Give Year or Dates:	?		Vas Decedent of Yes, specify Cul ☐ Yes 2X No			ecify Yes or No Rican, etc.)		14. Race - Amer Black, White Specify: BLA	, etc.
21215-0036	within 72 h iene. • than "natu ibe Madical	Completed	15. Decedent's E. (Specify only highest gra-			(Give l life. D	ent's Usual Occu kind of work done 10 NOT use retire	during me	st of work	ing		nd of Business/li	•
CA	Hygie Hygie other	ပိ	12 17. Father's Name (First, Middle, Last)			В	ARBER	18. Moti	her's Nam	e (First, Middle,		rber She	ops
lan	ould be Mental arked o	To B	George M. Trave	ers				Ma	ariet	ta Jewe	11	,	
Mar	1 and 2 should Health and Men iam 27 is marke other traumatic		19a. Inlomant's Name/Relationship (Marietta Jewell	Турв, Print)			g Address <i>(Stree</i> Wintergr					Town, State, Zi	
Baltimore,	of He of He of tarr		20a. Method of Disposition 1 ☑ durial 2 ☐ Cremation 3 ☐	Removal from State	l come	of Dispos etery, crem	sition (Name of natory or other pla	ice)	AUG	Date	20c. Lo	cation - City or T	own, State
ţ	thent of the tant: If its		4 Donation 5 □ Other (Specif	y)	Line		Cemetery		Jul			tland M	
Bal	permit. Page Department of important: ff any injury or ance.		21 Anatuse of Funeral Service Ucer 23a Part I Enter the disease, or com shock or heart failure. List only	ums	>	L	Name and Addr	Fune	ral H	iome WDC	200	orgia A 11	ve NW
	cate be executed hysician and hysician and hysician and hysician and ithe parial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, If any, basing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or so	s a consequence	ce ol): ta 너):	NRIES						200
Box 6	death certifi e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal dea	ath 3	Ectopic pregnand Other (specify)	;y			2	23d. Date ol delio Month	very Day Year
rds, P	quires that in signed build be det	þ	Part II. Dther significant conditions of	ontributing to death	but not resultin	g in the un	derlying cause g	ven in Part	: I.		obacco u Yes 2		the cause of death?
	ician: The law requires that the certificate has been signed by thi ector, page 2 should be detache	Completed										24b. Were aut prior to co death?	opsy findings available ompletion of cause of 2 \square No
Vital	Physician; this certific ral director,	o Be	25. Was case relerred to medical examiner? XXYes 2 \(\) No	Hospital:	all ED	/O. 441	05	han		h (Check only o		VV.	CCENE
of	ding After fune	tion: To	27. Manner ol Death 1 Natural 5 Pending 25. Accident investigation	28a. Date ol Inj (Month, Da	ury 28l	Outpatient b. Time of Injury	28c. Inju	4 🗆 🗅		28d. Describe I	how injury	_	IN COLLING
Division	P di ii	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Inbuilding, e	njury - At home tc. (Specify)	, farm, stre	eet, factory, office			HARRY ST	vn, State) RL/17Fi	N OF AT	PRINCE PLACE
	Hosp 24 hou Fune stely fil	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the besi	of examination	dge, death and/or inv	occurred at the testigation, in my	ime, date a opinion, de	and place, eath occur	and due to the red at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Mec	29b. Signature and title of certifier	and manner s	ialeu.			se number M E	,			e signed (Month	
	١		30. Name and address of person who	completed cause of	death (Item 23	(Type, F	Print) 11 PENN	STRE	ET, E	BALTIMOR	Œ, M	IARYLAND	, 21201
	Sta Regist		31. Date liled (Month, Day, Year)		trar's Signature	_	inelle !						

State Registrar Pamela E. Southall, MD
31. Date filed (Month, Day, Year)

AUG 0 4 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M) 111 Penn Street, Baltimore, Maryland 21201
Registrar's Signature

Maryland 21201

amend 1 ,18 per Dr. Please Type of Frink BHBlack Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U U 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 07 1210 amons. Jochim 23 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center Baltimore City Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 💢 F Director none 20 July 23, 2005 Maryland Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28e-f show other treumatic svent, the Modical Examination rust by notified at MD 1√2 Yes 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3700 W. Garrison Avenue Funerai 21215 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: δ Specify: 3 Widowed 4 Divorced black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ges 1 and 2 should be filed within t of Health and Mental Hygiene. If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) none none none none 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) Be Annie Joschim Jochim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) University of Md Hospital 22 S. Green Street Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ permit, Page Department of Importent: If any injury of `4 □Donation 5 NOther (Specify) in state 21. Signature of Funeral Service Licensee Ronal S Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street B:

23a. Part. Enter the disease, or complications that caused the death. Do not enter shock or heart failure. List only one cause on each line. Baltimore, MD 21201
nter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician extreme prematurity one hour disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter the design of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by page 2 should be none 1 ☐ Yes 2 📉 No 3 Probably 4 □Unknown Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 2 No certificate the Hospitei or Attending Physicien: the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 Homicide within 24 hours a

To the Funerel I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Malisa 0-658-222-5 M.D. 23

State Registrar

DHMH 17 Rev 1/2001

225, Greene Street, Baltimore, MD21201

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KOji MATSUO, 31. Date filed (Month, Day, Year)

AUG 0 4 2005

d1		1 - State Amend Item 1&	State of Marylan Unpend Item 2	d / Depa 3a&27 <i>Cer</i>	rtment of	Health and N G846 8-18-	Mental Hygie 05 tas	ne2005	25453
2 14 34	The state of	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
Physici /Medic		Ronald Keyes,	Sr.				July 18,	2005	4:30 P M
Examin	er	4a. Facility Name (If not institution, give since 111 Aspenwood Way			4b. City, Town, Baltime	, or Location of Death Ore		4c. County of Dea	
Funeral		Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Day	ar If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Bir	thplace (State or Foreign
Director	Š	unknown Usual Residence of Decedent	62	Yrs.			7/5/4:	3 Mar	yĺand
land		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
Marylan of ehow	ţō	Md Baltim	ore	R ₂ 1	timore	2			1 ☐ Yes 2 🗷 No
h the or 28s	Director	10e. Street and Number	OIC	Dai	10f. Zip Code		10g.	Citizen of What Co	ountry?
23a c		111 Aspenwood W	ay Apt. 1	. D	21	237		USA	
tems	Funeral		12. Was Decedent Ever in U. Armed Forces?	S. 13. V	Was Decedent of f Yes, specify Cu	f Hispanic Origin? (Spuban, Mexican, Puerto	ecrfy Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
rs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 221No If Yes, Give Year or Dates:		1□Yes 2 <mark>X</mark> N	lo Specify:		Specify: T	Th i to
2 hou		15. Decedent's Educ	cation	16a. Deced	lent's Usual Occ	cupation	16	o. Kind of Business	White
Media	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life. L	kind of work don DO NOT use reti	ne during most of work ired)	king		
ad wit	Completed	Ó	0		unkno			unkno	nwo
I all y ratio A 12.15.15.05.05.05.25.25.25.25.25.25.25.25.25.25.25.25.25	Be	17. Father's Name (First, Middle, Last) unknown					e (First, Middle, Ma.	den Sumame)	
y Nould	P		no Printl	10h M-ili-	- Add (Ct	unkn		T 0-4	7-0-41
C, INCI VIC		19a. Informant's Name/Relationship (Type Mr. Ronald Keye				Grove Ct		•	
s 1 and 1 Health Item 27 other tr		20a. Method of Disposition	20b. P	face of Dispo	sition (Name of natory or other p			c. Location - City or	
Pages nent of I int: If its		1 ☐ Burial 2. A Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		, ,	ory 7/2	8/05	Baltimor	e. Md.
permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other tra		21. Signature of Funeral Service License				vski factivune			,
83558		Lugene)	· Cost of	- 12	201 Dur	ndalk Ave	. Balti	nore, Mo	1. 21222
		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the death ie cause on each line.	n. Do not ent	er the mode of d	lying, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	Atherosclero		rdiovaso	cular Dise	ase		Cristiana Scatt
/Medical Examiner		1	Due to (or as a consequ	uence of):					
** ** ** ** **	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):					
cuted Id ransit	Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events							
icate be executed physicien and sthe burial-transit		resulting in death) Last	Due to (or as a consequence	uence of):					
ate by	dicai	d							,
eath certific attending p	0	IF FEMALE:	3c. If yes, outcome of pregna	IDCV				001.01.11	
eath c	cian	in the past 12 months?	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	I death 3	Ectopic pregnar Other (specify)			23d. Date of de Month	Day Year
oy the gached	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						1
ries that the de signed by the a	by P	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause	given in Part I.	23e. Did tobac	co use contribute t	o the cause of death?
w require been sig							1 ☐ Yes	2 □ No 3 □ P	robably 4 Unknown
faw r has be	Completed						24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
VIIAI NEI iician: The lav certificate has rector, page 2	Con						1 Yes 2	d? death?	
VIIC iician certifi rector	Be	25. Was case referred to medical warniner?	lospital:		- 10	Date	th (Check only one)		
P Py C	7. To	1 ✓ Yes 2 No	1 Inpatient 2	ER/Outpatier 28b. Time of	1 3 DON	4 Nuising H	ome 5 Residence		cify) scene
ath.	atior	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	f 28c. In	vork? □Yes 2□No		,,	
VISION OF VICE THE TAR Attending Physician: The lay of Geath. •ctor: Affer this certificate has by the funeral director, page 2	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, str	eet, factory, offic	De .	28f. Location (Stree City or Town, S	at and Number or R	ural Route Number,
is after 2	Cert		building, etc. (Opecin	,, 			Only or Town, S	naie)	
To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detected for use as the burial-transit	Medicai	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examination	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or in	h occurred at the vestigation, in m	e time, date and place, y opinion, death occur	and due to the caus red at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
Fo the vithin. Fo the comple	Me	29b. Signature and title of certifier	and mainter states.		29c. Lice	ense number	29d	Date signed (Mon.	th, Day, Year)
, , , , , ,		1 Sancti Fruit	hall per		OCM	E	Т.	uly 19, 2	.005
		30. Name and address of person who co		1 23a) (Type,	Print)				
		Pamela E. Sout	1127		111 Pe	nn Street,	Baltimor	e, Maryla	nd 21201
Sta Regist		31. Date filed (Month, Day, Year)	32. Porterar's Signa	iture	A. Mi				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No.) 2. Date of Death . Decedent's Name (First, Middle, Last) Dav **Physician** 07/30/2005 5:15 PM Paul Elmer Klatt /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pasadena Anne Arundel Oak Lodge Senior Home If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 6. Sex Months 1 MM 2 □ F Director 85 08/02/1919 MD 214-20-0408 Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artinent of Health and Mental Hygiene. ortants if Itam 27 is merked other then "natural; or Itams 23a or 28a-1 show injury or other traumatic event, Ita Maryland Itams 23a. 1 Yes 2 No Directo Glen Burnie MD Anne Arundel 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code Court 21061 U.S.A. Funeral 6504 Home Water 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 XYes 2 No 1944 1 Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: ð 3 Widowed 4 Divorced 1946 White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Engineer U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rudolph Klatt Genevieve Deppish 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5999 Calvert Way, Eldersburg, MD 21784 Paul F. Klatt / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 08/02/05 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) permit,
Departm
Importa
any inju 22. Name and Address of Facility G.J.Gonce Funeral Home, PA 21. Signature of Feneral Service Licenses <u>169 Riviera Drive, Pasadena, MD 21122</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician <u> Alzheimers Disease</u> /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Figury Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical attending physic 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown <u>Parkinsons Disease</u> Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has page 2 s autopsy certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attanding Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 2 s after de... ral Diractor: After ... this 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Oescribe how injury occurred Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L 29a. Certifier 🛣 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 05 ve D34109 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Michael Sylva

AUG 0 4 2005

31. Date filed (Month, Day, Year)

ORIGINAL

Veterans Hwy, Millersville, MD

8601

32. Registrar's Signature

			For State Registrar	State of N	Marylar		artment o			and M	lental Hy	/gien Reg. N	000		05	· [-
			Decedent's Name (First, Middle, L.	ast)					-		2. Date of Do	eath		9	3. Time	of Death
	Physici /Medic		Charles Edwar	cd .	Kil:	lmayer	, Jr.	_			8	1	2005		5:45	АМ
	Examin		4a. Facility Name (If not institution, gas 3914 Dunes Way	ve street and numbe	er)		4b. City, To		Location o			1	c. County of D Montgon		,	
-	Funeral			Sex 7.7	Age (In yrs.	last birthday)	If Under 1 \	/ear	If Under	24 Hrs.	8. Date of Bi	rth	0			or Foreign
	Director		213-52-7359	1₽M 2□F	51	Yrs.	Months D	ays	Hours	Min.	6/19/1	954	MA	Counti RYL	ÄND	or Foreign
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10	d. Inside (City Limits
	Mary 1 sho	ţō	MD MONTGON	IERY	BU	RTONSV	ILLE								1 ☐ Ye	s 2XXVo
	th the	Director	10e. Street and Number				10f. Zip Co	ode				10g. C	itizen of What	Count	y?	
	eth wi	rai	3914 DUNES WAY					866					5.A.			
9500-61212	be filed within 72 hours after deeth with the Maryland ital Hygiene. d other than "natural", or iteme 23a or 28a-f show event, The Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give Year or Dates	s? XNo		Was Deceden If Yes, specify 1 ☐ Yes 2		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - A Black, W Specify: W	hite, e	tc.	
ر ک	72 hc 'natur	eted	15. Decedent's t (Specify only highest g			(Give	dent's Usual C	done di	urina most	of worki	ng	16b.	Kind of Busine	ss/indu	istry	
7	within ane. than	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)	SAL	DO NOT use i ES	etired)				1	TOMOTUA	'TVF		
	Hygir other	Be Co	17. Father's Name (First, Middle, Las	t)		ULIL			18. Mothe	r's Name	(First, Middle	_		111		-
<u>Ja</u>	should be merked o	To B	CHARLES EDWARD	KILLMAYER	, SR.				RUT	H I	ECOURS	Y				
, Maryland	s 1 and 2 should f Heaith and Men ltem 27 is marke other traumatic		19a. Informant's Name/Relationship CHARLES E. KILLN			60 J	OHNSON	RO					or Town, State 21122	в, <i>Zip</i> (iode)	
altimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Removal from Stat	te (cemetery, crei	natory or othe	r place	·		ate		Location - City			
	permit. Page Depertment of Important: If any injury or once.		4 □Donagon 5 □Other (Spec 21. Signat of 1 eral Service Uce		Сн		KE CREN 2. Name and A				2005		EVENSVI JNERAL			Λ
n	Ped Per Per Per Per Per Per Per Per Per Per		May V	/	01120								NIE, MD			n.
)	Physician /Medical Examiner	(23a. Part1. Enter the disease, or conshock, or heart failure. List online disease or condition disease or condition distingtion in death)	a. Simulation of a Due to (or a	iline.	ell	er the mode o					arrest,			Approxima Interval Be Onset and	d Death
, 00,	icate be executed physicien and s the burial-transit	i Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a												
98/60	physic	dicai		d										-		
O. Box	requires thet the death certifi veen signed by the ettending I hould be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Feta at time of c	al death 3]Ectopic pregr] Other (speci						23d. Date of Month		y Day	Year
1	es thet igned b be deta	by Pi	Part II. Other significant conditions	contributing to death	but not res	sulting in the u	nderlying caus	e give	n in Part I.		23e. Did	tobacco	use contribute	to the	cause of	death?
g	v require been sig should b	ted	SIADH								10	Yes 2	2 □ No 3 □	Probal	oly 4 🗆]Unknown
Vital Records,	The law ete has t page 2 s	Completed									24a. Was auto perfe 1 Yes		24b. Were prior death	autops to com 1? 'es 2		s available cause of
	Physicien: Th this certificete ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpa	tiont 2	ER/Outpatier	nt 3 DOA	Other			(Check only		A [] 011 (6			
ō	g Phy er this eral d	n; To	27. Manner of Death	28a. Date of In	ijury	28b. Time of		Injury Work	4 🗆 Nui		ne 5 🔀 Hes 28d. Describe		6 □Other (S ury occurred	pecity)		
<u> </u>	Attending In death.	atio	1 Natural 5 Pending 2 Accident investigate	on	yay rear,	Injury	М		es 2 🗆 N	No						
Division	tal or Att s efter d al Direct ed in by t	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	286. Place of I	njury - At h etc. <i>(Specil</i>	ome, farm, str fy)	eet, factory, of	ffice		1	28f. Location (City or To	Street a wn, Stat	nd Number or te)	Rural	Route Nur	mber,
	To the Hospital or Attent within 24 hours effer deati To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exe	thysician: To the best miner: On the basis and manner	of examina	owledge, deatl	n occurred at t vestigation, in	he time my opi	e, date and inion, deat	d place, a	and due to the ad at the time,	cause(s	s) and manner nd place, and c	as stat	ed. he cause((s)
)	To t Com	Σ	29b. Signature and title of certifier	\mathcal{W}	\bigcirc		_		number	SY		29d. D	ate signed (Mo	onth, D.	ay, Year)	
1	7	1	30. Name and address of person who	completed cause of	death (Iter	n 23a) (Type,	Print)	O	24 -	12			14		_	15
	Sta	te	31. Date filed (Month, Day, Year)	32. Reg	rar's Signa	ature .	1100	4	9	DV	TCTIV	V-01	Len	W.	اداد	V
	Registr		AUG 0 4	2005	dua	J.	Sports	•								

DHMH 17 Rev 1/2001

			FOI	Maryland / Depa			ntal Hygie	ne	
			1 - State Registrar	Ce	rtificate of E		Reg.	No2005	25456
	Physici	an	Decedent's Name (First, Middle, Last)		VOE		Month	Day Year	3. Time of Death
	/Medic		JOSEPH 4a. Facility Name (If not institution, give street and numb	er)	4b. City, Town, or		OLY BI	4c. County of Death	5:57 "M
	Examir	lei	SINGI HOSPITAL OF		BALTIMS	_	TY	N/	'A
	Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth Month, Day Ye	9. Birthp	place (State or Foreign
	Director		220-10-/1/0	84 Yrs.)3/18/19:	21	VA
	land land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			t	Od. Inside City Limits
	Many a-1 sh	tor	MD BALTIMORE	RANDALLS	STOWN				1 ☐ Yes 2 ☐ No
	th the	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cour	ntry?
	ath wi	ral	3913 ALGIERS ROAD		21133			U.S.A.	
	er de	Funeral	11. Marital Status 12. Was Decede Armed Force 1 Never Married 2 Married 1 Yes 2	TAT NI -		spanic Origin? (Specif n, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Americ Black, White,	
336	ours after death with the Marylan rei', or Itema 23a or 28a-f show Examiner coust be confilled at	by F	3 ☐ Widowed 4 ☐ Divorced Year or Date		1 ☐ Yes 2 No	Specify:		Specify: WH]	TE
21215-0036	72 hours after death with the Maryland "neturel", or Itema 23a or 28a-1 show olical Examinational Decirolitied at	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupa	tion		. Kind of Business/In	
2	l within 72 ho jiane. r than "natur ine Medicel	Completed	Elementary/Secondary (0-12) College (1-4	or 5+) ELECT	DO NOT use retired) RICAL INS	Uring most of working TRUMENT		RYLAND ELI ESTING	ECTRICAL
2	filed w I Hygier other the		17. Father's Name (First, Middle, Last)	TECHNI	LCIAN	18. Mother's Name (F			
Maryland	be d la	o Be	MAX	KOFSk		PEARL		AZANOFSKY	
ary	2 should and Men Is marke sumatic	-	19a. Informant's Name/Relationship (Type, Print)		-	nd Number or Rural R	loute Number, Cit	ty or Town, State, Zip	
	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		SELMA KOFSKY / WIFE			ROAD - RAN			
Baltimore,			20a. Method of Disposition 1	20b. Place of Dispo	natory or other place	Date		. Location - City or To	
Ħ	F F F		* 4 □ Donation 5 □ Other (Spegify) 21. Signeture of Funeral Service Legislee			08/01/ s of Facility SOL L		ALTIMORE,	
Ba	permit. Departr Imports any inju		Millian Trues			RSTOWN ROA			
	77 77 14		23a. Part1. Enter the disease, or compli ations that cau shock, or heart failure. List only the cause on each						Approximate Interval Between
	Physician [°]		Immediate Cause (Final disease or condition	cerebro Va					Onset and Death
	/Medical Examiner			as a consequence of):					
		P.	Sequentially list conditions, if any leading to immediate Due to (or	as a consequence of):					
1	uted d ansit	mlner	if any, leading to immediate Cause (Disease or injury that initiated events						
oʻ	te be executed ysicien and ie burial-transit	Exam	1 141 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	as a consequence of);					
8760	ü ← +	dlcal	d						
9	eath certific attending p	/Me	IF FEMALE: 23c. If yes, outco	ne of pregnancy				23d. Date of delive	arv
Вох	atten atten	Physician/Me	in the past 12 months?	2 Fetal death 3	Ectopic pregnancy Other (specify)			Month	Day Year
0	that the de led by the a detached	hysi	9 ☐ Unknown 9☐ Unknown	1					
s, P	es tha igned be de	by P	Part II. Other significant conditions contributing to deat	h but not resulting in the u	inderlying cause give	n in Part I.		co use contribute to the	
ord	w requir been si should	ted	Hyperlension				1 🗌 Yes	2 No 3 Prob	ably 4 Unknown
Vital Records,	e law re has be	Completed	NON Insulin depen	1 do Nt			24a. Was an autopsy performed	prior to cor	psy findings available mpletion of cause of
alF	ician: The l certificate ha rector, page		V				1 Yes 2 €		No No
	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inp	atient 2 ER/Outpatier		26. Place of Death (C 1 □ Nursing Home		6 Other (Specific	w)
10		\vdash	27. Manner of Death 28a. Date of			at 280	I. Describe how in		V/
ion	Attending Fir death. ector: After by the funer	atlo	2 Accident investigation	Day 7 Gary Injury		es 2 No			
Division	al or Attend after death Director: / d in by the f	Certification;	3 Suicide 6 Could not be determined 28e. Place of building.	Injury - At home, farm, str etc. (Specify)	reet, factory, office	28f.	Location (Street City or Town, St	and Number or Rura ate)	l Route Number,
	Hospital of the Hours a Funeral C		29a. Certifier Certifying Physician: To the be	set of my knowledge, death	h occurred at the time	e date and place and	due to the cause	a(s) and manner as st	tated
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Examiner: On the basione)	s of examination and/or in	vestigation, in my opi	inion, death occurred	at the time, date a	and place, and due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License	number	29d. I	Date signed (Month,	Day, Year)
)			Sharing MD		RES	-000	J	ULY 30	2005
	10		30. Name and address of person who completed cause of			11		Qu/ T	1.000
	Sta	te	31. Date filed (Month Pay Year) AUG 0 4 2005	EIEF MD istrar's Signature	SINAI	ALPANIASOM T	CC	BALT	THORE
	Regist		AUG 0 4 2005	en & A	books				

JOSEPH

くのアタガイ

0

CROWN

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Month Ernest Kavadas /Medical July 20. 2005 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 608 Bowman Drive Salisbury Wicomico 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 17, 1925 9. Birthplece (State or Foreign County) Washington DC **Funeral** 1**∑**M 2□F Days Director 79 577-26-8609 Usual Residence of Decedent 10a. State 10c. City, Town or Location or 28a-f show 10d. Inside City Limits ral', or items 23a or 28a-f show Director MD Wicomico 1 ☐ Yes 2 ☑ No Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 608 Bowman Drive 21804 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☒ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No δ 3 Widowed 4 Divorced Specify: white "natural", Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) 12 minister religion other traumatic event, 17. Father's Name (First, Middle, Last) ages 1 and 2 should be fill out of Health and Mental H t: If Item 27 is marked oth Be 18. Mother's Name (First, Middle, Maiden Sumame) Gus Kavadas ျှ Martha Smithers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ida Kavadas/spouse 608 Bowman Drive Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c, Location - City or Town, State Pages 0 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. * 4 ☑Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee State Anatomy Board 655 W. Baltimore Street VIU 21201 Baltimore, MD 23a. Part1. Enter the disease, or com shock, or heart failure. List only or complications that causist only one cause on each Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediete Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death Year 5 Other (specify) the 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24e. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? has 1 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death After 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Natural 5 Pending after death 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certific who completed cause of death (item 23a) (Type, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

		•	1 - For State Registrar		rtment of Health and Me tificate of Death	ental Hygien	
F	Physici		1. Decedent's Name (First, Middle, Last) KENNETH	LEI	CIIT	2. Date of Death	ay Year 3 Time of Death 8
	/Medic Examin		4a. Facility Name (If not institution, give street and	number)	4b. City, Town, or Location of Death BALTIMORE		c. County of Death Baltimore Co.
	Funeral Director		5. Social Security Number 6. Sex 13-26-4734 1 ★ 2□ F	7. Age (In yrs. last birthday) 75 Yrs.	Months Days Hours Min.	B. Date of Birth (Month, Day, Year Feb. 13,19	9. Birthplace (State or Foreign Country)
	the Maryland 28a-f show notified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland 10e. Street and Number	10c. City, Town or Loc	Dundalk	10a. C	10d. Inside City Limits 1 □ Yes 2∑ No
36	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "neturel", or Items 23e or 28a-f show event, the Mcdical Examiner must be notified at	by Funeral DI	1910 Nevill Road 11. Marital Status 1 Never Married 2 Married 12. Was D Armed 12. Was D Armed 15. Was D Arme	Forces? If	21222 Vas Decedent of Hispanic Origin? (Spec Yes, specify Cuban, Mexican, Puerlo R ☐ Yes 2₹\$\text{No} Specify:	ify Yes or No-	nited States 14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	filed within 72 hou Hygiene. other than "neture ent, the Wedical E	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) Colleg	ed) 16a. Deced (Give I life. L	ent's Usual Occupation kind of work done during most of workin OO NOT use retired) Ck Driver	9	Kind of Business/Industry Trucking
ryland	2 should be file and Mental Hy Is marked oth sumatic even	To Be	17. Father's Name (First, Middle, Last) Arthur Leicht 19a. Informant's Name/Relationship (Type, Print)	10h Mailin	18. Mother's Name Emma We		
	l and 2 lealth a im 27 ls		Mrs. Malvonna Leicht/ 20a. Method of Disposition	Wife 1910	Nevill Road Du	ndalk, Mar	
Baltimore,	permit. Pages i Department of H Important: If ite any injury or ot once.		1 ⊠Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify) 21. Signature of Jun 1al Set Of Licensee	Holly Hill	11 Mem. Gdns. 8/3/. Name and Address of Facility da-Ruck Funeral Ho	me of Dur	
STATE STATE OF	Pnysician /Medical Examiner			at aused the death. Do not enter the each line. to (or as a consequence of):	22 Wise Ave. Dund or the mode of dying, such as cardiac or		Approximate Interval Between Onset and Death
68760, F	the death certificate be executed y the attending physician and tched for use as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	to (or as a consequence of):			
P.O. Box (that the death certific ed by the attending p detached for use as	Physician/Me	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
	law requires that as been signed b 2 should be deta	by	Part II. Other significant conditions contributing t	o death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Vital Records,	The ate has page	Completed	Connany	Artery	Disease	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
of	ding Physicien: Th h. After this certificate funeral director, pag	on: To Be	the second second	☐ Inpatient 2 ☐ ER/Outpatient ate of Injury fonth, Day Year) 28b. Time of Injury			6 □Other (Specify) ury occurred
Division	or Atten ifter deat Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e. Pl	ace of Injury - At home, farm, stre uilding, etc. (Specify)	M 1 Tyes 2 No	Bf. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospitel or Attenwihin 24 hours after deall To the Funerel Director: completely filled in by the	edicai	(Check only 2 Medical Examiner: On the one) and n	the best of my knowledge, death e basis of examination and/or invanner stated.	occurred at the time, date and place, a estigation, in my opinion, death occurre	d at the time, date a	nd place, and due to the cause(s)
)	with To 1	M	29b. Signature and title of certifier 30. Na e any addres of person who complete of	ause of death (Item 23a) (Type	29c. License number DOGG ZO3 Z		No. 21224
	3+1 Sta	ate-	Jenniter Hayashi, MD 5	505 Hopkins (BAYVIEW CIRCLE, B	ALTIMORE, 1	MD 21224
	Regist		AUG 0 4 2005	2. Registrar's Signature	parle		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Herbert V. Miller 2005 August /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Lorien Nursing Home Airy Mt. <u>Carroll</u> If Under 1 Year If Under 24 Hrs. A Date of Birth (Month, Day, Year)

Months Days Hours Min. (Month, Day, Year)

Aug. 21, 10 9. Birthplace (State or Foreign Country) 1926 West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1₩ M 2□F Months 298-26-8433 78 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Nedical Examilment rust be multified at 1 Yes 2 □ No Director Mount Airy Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21771 713 Midway Avenue Pages 1 and 2 should be filed within 72 hours after death vent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: White 3 ₩ Widowed 4 Divorced WWII Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Navy 4 Master Chief Hospital Corpsman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Grace Loughry 0scar Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2406 Freetown Drive, Reston, Virginia 20191 Thomas A. Miller - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Parklawn Memorial Park 8/6/05 Rockville, Maryland 4 □ Ponation 5 □ Other (Specify) 22 Name and Address of Facility Olin L. Molesworth P.A., Funeral Home 21. Signature of Puneral Service Licensee overe 26401 Ridge Road, Damascus, Maryland 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ZHEIMERS **Physician** months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine signed by the attending physician and d be detached for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 1 Yes il or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 40 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) Certification: 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No investigation 2 Accident by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital c within 24 hours af To the Funeral D 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License number D26499 August 2, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ronald E. Miller M.D. #4 Culwell Drive, Mt. Airy, Maryland 21771 31. Date filed (Month, Day, Year) 32. Restrar's Signature State AUG 0 4 2005 Registrar

			For State Registrar	S	tate of	Maryla	nd / Depa		ent of H		and M	lental F	lygien Reg. N	20	Ω 5	25460
	Physici		Decedent's Name (First, Midde Eleanor Mary	, ,	1							2. Date of		ay	2 OO	3. Time of Death 7: 00 P. M
	/Medic Examir		4a. Facility Name (If not institution			ber)		4b. Cit	y, Town, or	Location of	of Death				nty of Dear	
п			Union Memori	al Hos	spita]	L		Ва	altimo	ore						
	Funeral Director		5. Social Security Number 375–16–2438 Usual Residence of Decedent	6. Sex 1 ☐ M	2 🔀 F	'. Age (In yrs 87	. last birthday) Yrs.	If Und Month	ler 1 Year s Days	If Under: Hours	24 Hrs. Min.	8. Date of (Month, Aug 1		r) 917	Co	thplace (State or Foreign buntry) higan
	land		10a. State 10b. Count	у		10c. C	ity, Town or Lo	ocation								10d. Inside City Limits
	Many 4 sh	ţō	MD				Balti	more								1 ▼ Yes 2 □ No
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Exactine mast be notified at	Director	10e. Street and Number					10f. 2	Zip Code				10g. C	itizen o	of What Co	ountry?
	th wit	a D	189 Hollen Ro	ad					212	12				USA	Δ	
	dea	ner	11. Marital Status	12.	Was Deced	lent Ever in t	J.S. 13.	Was Dec	edent of Hi	ispanic Orig	gin? (Spe	ecify Yes or Rican, etc.)	No-	14. Ra		erican Indian,
36	or it	by Funeral	1 X Never Married 2 Ma	rried	1 ☐ Yes 2 If Yes, Give Year or Dat	₹ No			2 ∏ No	Specify:	, , , , , , , , , , , , , , , , , , , ,	1110411, 010.7		Spec		
Maryland 21215-0036	ural		3 Widowed 4 Divorce			tes:	1								- W	hite
5	"nat	Completed	15. Decede (Specify only high	nt's Educati est grade co	on impleted)		(Give	kind of	sual Occupa vork done d use retired	during most	t of worki	ng	16b.	Kind of	Business/	Industry
7	within than than	шс	Elementary/Secondary (0-12)		College (1-	4or 5+)			arian	,				برداده	+	
0	Hygie other	BeC	17. Father's Name (First, Middle	, Last)	~			LIDIO	ar ran	18. Mothe	r's Name	(First, Mide			catio ^{ame)}	011
au	should be tand Mental I s marked or umatic eve	To B	Clark D.	Mason	n					G	race	Stode	lard			
ary	2 should be and Mental is marked sumatic ev	-	19a. Informant's Name/Relation	ship (Type,	Print)		19b. Mailie	ng Addre	ss (Street a	and Numbe	r or Rura	I Route Nui	nber, City	or Tow	n, State, 2	Zip Code)
	1 and 2 Health a lem 27 is		Julian Lapide	s/atto	orney		2 Ha	mi11	Road	1 #332	2 Bal	Ltimor	e, M	D 2	21210	
altimore,	of He of He roth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	2 🗆 🗆			Place of Dispo	sition (N	ame of other place	e)	C	ate	20c. l	ocation	n - City or	Town, State
Ĕ	Pages nent of I ant: If ite		`4 Donation 5 Other (oval from S	late			·							
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: it item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Exact at most be notified at once.		2 Stratury of Euneral Service Ronal d	Licensee Wa	de, 16	de co	r St	tate	and Addres Anato nore,	ony Bomb	oard 2120	655 V	√. Ba	lti:	more	Street
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	complicati	ons that car ause on ea	used the dea	th. Do not ent	er the m	ode of dyin	g, such as	cardiac o	rrespirator	y arrest,			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		ASI	DIRK	710,	\sim	PM	JEI	11	101	MA			Onset and Death
Г	/Medical		resulting in death)	(a		r as a conse										3,1,13
	Examiner		Sequentially list conditions,	b												
	sit ad	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	~	Due to (o	r as a conse	quence of):									
	and I-tran	хаш	that initiated events resulting in death) Last	c	Due to (o	r as a conse	nuance of):	_								
8760,	ate be executed hysician and the burial-transit	E			0) 01 600	1 43 4 001136	quence on.									
387	phys phys the	dlcal		d.											-	
9 xo	The law requires that the death certificate be executed to has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c.	If yes, outco	ome of pregn	ancy							224 5	ate of deli	inos.
B	atter after 1 for u	clar	in the past 12 months?		1 Live bir	th 2 ☐ Fetant at time of	al death 3[Ectopic Other	pregnancy specify)						Month	Day Year
0	that the de ed by the a detached f	hysi	1 □ Yes 2 ☑ No 9 □ Unknown		9 Unknov	vn										
S, D	res that igned b		Part II. Other significant condit	ions contrib	uting to dea	th but not re	sulting in the u	nderlying	cause give	en in Part I.		23e. Di	d tobacco	use co	ntribute to	the cause of death?
200	w require been sig should b	ed b	DYSPHAG	IA,		PIN	AL -	SU	RAI	E/R)	Y .	1 (☐Yes 2	⊇ □ No	3 🗌 Pr	obably 4 Hrknown
Vital Record	s bee	Completed by										24a. W	as an	24b	. Were au	topsy findings available
ž	The lav	ШО											topsy erformed?		prior to death?	completion of cause of
<u>ia</u>	yslcian: The is certificate director, pag	BeC	25. Was case referred to medic	al						26. Place	of Death	(Check onl			1 0 103	
<u>></u>	nysic nis ce I direc	70 [examiner? 1 Tyes 2 Ne	Hosp	المهنستة		ER/Outpatien	nt 3 🗆 f	Othe Othe	er: 4 □ Nur	rsing Hor	ne 5 Re	esidence	6 🗆 🗆	ther (Spec	cify)
0	ding Phy h. After thi funeral o		27. Manner of Death 1 ☐ Natural 5 ☐ Pend		8a. Date of (Month)	Injury Day Year)	28b. Time of Injury		28c. Injury Work	at	2	28d. Describ	e how inju	ary occu	urred	
Sio	tendii Jeath. tor: A the fu	catl	2 Accident invest	igation				М		/es 2□N	VO					
Division of	or Attendation director:	Certification:	3 Suicide 6 Could 4 Homicide determ		8e. Płace o building	f Injury - At h g, etc. (Speci	iome, farm, str fy)	eet, facto	ory, office		2		n (Street a Town, Stat		nber or Ru	ral Route Number,
	ntal c ral D ral D															<u> </u>
	Hospital 24 hours 2 Funeral Itely filled	edical	(Check only 2 Medica	ng Physicie Examiner:	On the bas	is of examina	owledge, death ation and/or in	n occurre vestigatio	d at the tim on, in my op	e, date and pinion, deat	d place, a h occurre	and due to the	ne cause(s e, date an	s) and m nd place	nanner as e, and due	stated. to the cause(s)
	To the Hospital or Attending Physician: white 24 hours after deals. To the Funeral Director: After this certifica completely filled in by the funeral director,	Med	one) 29b. Signature and title pi certifi		and manne	r stated.			9c. License	-						n, Day, Year)
	5 7 K 7		A YELL	-	nan	19	MD				3					21,2005
			30 Name and address of name	000		-,		Print)	1141	1/21- 2	ADI	F 1. 00	242.0		10	00000
			30. Name and address of person SEPH 31. Date filed (Month, Day, Year		itu	MAAA	UA C	201	E-	un	40	PK	ivy	0, 1	342	TIMORIE TO 2/2/8
	Sta Registr		AUG 0 4	2005	Silve.	gistrar's Sign	A CONTRACTOR								1-4	1- 3/3/15

		For State Registrer	State of M	Maryland		artment of F		Mental Hy	giene	0.0	001	-
Physicia		1. Decedent's Name (First, Middle,						2. Date of D	eath L	Year	3. Time of D	ath
Physicia /Medic	al	Barbara	Ann		cher	Ab City Town o	r Location of Deal	Augus	t 4, 2	005	2:25	A₩
Examin	er	4a. Fecility Name (If not institution, s Stella Maris		er)		Timon		ın		timo		
Funeral Director		5. Social Security Number 219-26-8824	. Sex 7	Age (In yrs. Ia: 65	st <i>birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of B	irth ay, 1939	9. Birth Cou Ma 1	place (State or F ntry) 'yland	-oreign
Director		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City	Limits
4:35 A with the Maryland or 286-1 show	tor	Md. n/a			Balt	imore					1 ⊠ Yes 2	. □ No
4:35 with the Mary le or 286-1 sh	Direc	10e. Street and Number				10f. Zip Code	0.4		10g. Citizen of		ntry?	
eath w	Funeral Director	2609 Fait Ave	12. Was Decede	nt Ever in U.S	. 13.1	212		Specify Yes or N	US o- 14. Rac		can Indian,	
6 after d		1 ☐ Never Married 2 Marrie	Armed Force	s?		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☐ No		to Rican, etc.)		ck, White		
003 Nours	d by	3 Widowed 4 Divorced	Year or Date	s:					Specif	V	hite	
215-0036 215-0036 in "neturel", or Medical Exami	Completed	15. Decedent's (Specify only highest	grade completed)		(Give	ient's Usual Occup kind of work done DO NOT use retired	ation during most of wo d)	nking	16b. Kind of B	us iness/ir	ndustry	
212 212 212 213 Sgiene ser the	Som	Elementary/Secondary (0-12)	College (1-4d	or 5+)	С	ontrol					Maryla	ınd
Augus 174, 2005 21:35 feathmore, Maryland 21215-0036 Baltimore, Maryland 21215-0036 Depenti. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Disperment of Health and Mental Hygiene. Disperment of Health and Mental Hygiene. Disperment of Health and Mental Hygiene. Bright of Heart 21 is marked other then "neturel", or Items 23e or 28e-1 show eny injury or other treumetic event, the Medical Examinations to notified at once.	Be	17. Father's Name (First, Middle, La John J. Kolad						me (First, Middle ne A.	e, Maiden Suman Perc	ne)		
ryla in Merican marke	To	19a. Informant's Name/Relationshi			19b. Mailir	ng Address (Street				State, Zi	p Code)	
HUGUST Haltimore, Maryland mit. Pages 1 and 2 should be file partment of Health and Mental Hypoprient: if them 27 is marked oth y injury or other treumetic event se.		Edward G. Pal		sband)								368
Ore, of Herm		20a. Method of Disposition 1 □ Burial 2X Cremation 3	I □Removal from Sta	cei	metery, crer	sition (Name of natory or other place		Date	20c. Location	•		
Baltimo		`4 □ Donation 5 □ Other (Spe	ecify)	Вау		Cremat Name and Addre						PA
Bal permi Depar Impor		21. Signature of Funeral Service Li	land l			201 Dun						
		23a. Part1. Enter the disease, or c shock, or heart failure. List of	omplications that causely one cause on each	sed the death. h line.	Do not ent			c or respiratory	arrest,		Approximate Interval Betwee Onset and De	en eath
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	L un		CANO	ER					
Examiner			Due to (or	as a conseque	ence or):							
\$ P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseque	ence of):							
Kecute and I-trans	Examine	that initiated events resulting in death) Last	c	as a conseque	ence of):							
S AR H 8760, cate be executed obysician and the burial-transit			,									
R B Certificate reding physics as the	Medic	IE EENALE.										
HR R death certificate e attending pt	Physician/Medical	IF FEMALE; 23b. Was decedent pregnant in the past 12 months?		n 2 ∐ Fetal o	death 3	Ectopic pregnancy	/			ite of deliv	ery Day Ye	ar
O. I. O. I.	ysic	1 ☐ Yes 2 🕱 No 9 ☐ Unknown	4∐Pregnan 9□Unknow	t at time of dea n	ath 5∟	Other (specify) _						
\mathcal{FLCHRR} B.	by Ph	Part II. Dther significant condition	s contributing to deat	h but not resul	ting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use con	tribute to	the cause of dea	ath?
ords, P.	ted t							10	Yes 2□No	3 Pro	bably 4 Un	known
Peco Petawr has be	Completed							24a. Wa aut	s an 24b.	Were aut prior to co death?	opsy findings av ompletion of cau	allable ise of
H (all Re in The inficate ha	e Col	25. Was case referred to medical					26 Plans of Do	1 ☐ Yes	2 No	1 Tes	2 No	
of Vital of Vital Physicien: this certifica	To Be	examiner?	Hospital: 1 🗆 Inp.	atient 2 E	R/Outpatier	nt 3 DOA Ott	er	Home 5 ☐ Res		ner (Spec	HOSP	ice
n o n og Ph		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury	Wo		28d. Describe	how injury occur	red		
Vision Attending r death. sector: After	icat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	tion at be	Injury - At hor	ne farm str	M 1 □	Yes 2 □No	28f. Location	(Street and Numl	ber or Rui	al Route Numbe	97.
Division or Attential or Attential Director:	Certification;	4 ☐ Homicide determin	building,	, etc. (Specify)	110, 141111, 311	oot, ractory, office			own, State)			
Divisic To the Hospitel or Attent within 24 hours after deaut for the Funeral Director: completely filled in by the	edical (Physician: To the be xaminer: On the basi and manner	s of examination								
vithin To the comple	Me	29b. Signature and title of certifier				29c. Licens	se number		29d. Date signe	ed (Month	Day, Year)	
)				D	4372	5	8/	4/	05	
8		30. Name and address of person w	2	of death (Item	23а) (Туре,	Print) 23	00 D	ulan	ey Val	ley	Rd.	
Sta	te	31. Date filed (Madity AUG Pag)	h m o o d	istrar's Signati	ire	Fin	noniu	m, M	10 21	04	3	
Registr		HUG 0 4	2005	due s	B 1	osele						

DHMH 17 Rev 1/2001

CPM 05-05196 Keith Pitts, Sr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stete Registrer 1-Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) August 02, 2005 **Physician** 12:08 AM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore** 3243 Carlswood Circle Woodlawn If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth Month, Day, OCT. 12, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 12 M 2□ F 42 Yrs. Pennsylvania 170-52-8287 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a State 10h County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturet", or items 23s or 28s-f show any Injury or other traumatic event, it a Medical Examiner trausite and liberal once. 1 ☐ Yes 2 ☐ No Randallstown Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21244 3243 USA Completed by Funeral 12. Was Decedent Ever in U.S. Amost Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: Black 1□ Yes 2☑ No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOSPITA Electrician 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Gilber ueline Willara P 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Horton Pitts-Wife Randalls bun ms 21244 Circle 3243 arswood Debrah 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 □Removal from State 4 □Donation □ Other (Specify) Woodlawn Cemetery neral Service Lice se 23a. Party. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or rean failure. List only one cause on each line. Approximate Interval Between Onset and Death Acute Immediate Cause (Final trombosis coronau **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner been signed by the attending physician and should be detached for use as the burial-transit the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No 24a. Was an autopsy performed? 1 Yes 2 No or Attending Physicien: After this certific funeral director, 26. Place of Death | Check only one 25. Was case referred to medical Be examiner Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SCENE 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation illed in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by 4 | Homicide Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number O.C.M.E. August 02, 2005 who completed caus of death (Item 23a) (Type, Print) 30. Name and address of person GASV 111 Penn Street, Baltimore, Maryland 21201 V

Registrar DHMH 17 Rev 1/2001

State

2005

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

					Olato of	mar ylaria	Certifica	ite of	Death			Reg. No. 2	105	25	1.00
			1. Decedent's Nan	ne (First, Middle, L	a st						2. Date of Do	eath Day	Year	3. Finte of	Dedu J
	Physicia /Medic		514	DNFY	VALTE	4-					07	10	05	2-3	Am
	Examin		4a. Facility Name ((If not institution, gi					4b. City, To	own, or Lo	cation of Dea	th 4c. Count	y of Death		
			Sunrise	Assisted	Living	@ Pikesv	ille		Pike	esvil	1e	Balt	imore		
	Funeral		5. Social Security I	Number 6.	Sex	7. Age (In yrs. last		er 1 Year s Days		24 Hrs. Min.	8. Date of Bi (Month, D	irth lav. Year)	9. Birth Cou	place (State ontry)	or Foreign
	Director		212-07-4	+233	1∏ M 2□ F	96	Yrs.	Duyo	110013			2, 1908		yland_	
	D		Usual Residence											, 404 leelde C	in I inche
	rylan		10a. State	10b. County			own or Location							10d. Inside C	2 No
	e Ma	cto	MD	Baltimo	re	P	ikesvill								X
	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 Is marked other then "neturel", or items 23a or 28e-f show traumatic event, the Medical Examinating the mollified at	Director	10e. Street and Nu 3800	_{ımber} Old Cour	t Road		10f. 2	Zip Code	21208			10g. Citizen of	What Cou	intry?	
	s 23	Funeral				dent Ever in U,S.	13 Was Dec			rigin? (Spe	acify Yes or N	o- 14. Ra	ce - Ameri	ican Indian,	
	er de Item	Ě	11. Marital Status	ried 2⊠ Married	Armed For	ces?	If Yes, sp	ecify Cub	an, Mexica	n, Puerto	ecify Yes or N Rican, etc.)	Bla	ck, White		
20	rs aft	by F		4 ☐ Divorced	1 🔯 Yes If Yes, Give Year or Da	tes: ' 42 - 45	1 ☐ Yes	2 ∏ №	Specify	:		Speci	ty: wh	ite	
Maryland 21215-0020	ture			15. Decedent's 8	ducation		6a Decedent's Us	sual Occu	pation			16b. Kind of E	Business/Ir	ndustry	unk
15	in 72	Completed		cify only highest g	rade completed)	Apr Eu)	(Give kind of v	vork done use retire	during mos d)	st of worki	ing				
77	filed withi Hygiene. other then ent, the N	핕	Elementary/Sec 1.2	ondary (0-12)	College (1-	40(5+)	adı	ninis	trato	r					
D	filed Hyg ther ent,			(First, Middle, Las	t)				18. Moth	er's Name	e (First, Middle	e, Maiden Surna	me)		
an	ould be Mental marked o	То Ве	A1	bert Pal	tell				S	adie	Adalm	an			
<u></u>	2 should and Menis marked	F	The second second	lame/Relationship			19b. Mailing Addre	ss (Stree	t and Numb	er or Rura	al Route Numi	ber, City or Towr	, State, Zi	p Code)	
S	d 2 s			@ Pikesvi			3800 01	d Co	urt R	oad I	Pikesvi	ille, MD	212	208	
	s 1 and 2 if Health item 27 I other tra	10	20a. Method of Dis			20b. Plac	e of Disposition (A	lame of		1	Date	20c. Location			
ē	Pages ent of nt: If it ry or o			☐ Cremation 3 I 5 ☐ Other (Spec		State	etery, crematory o	r other pia	ice)	1					
Baltimore,	permit. Pages 1 a Department of He: Important: If item any injury or othe		21. Signature of F	uneral Service Lice Ronald S.	Wade D	integer	State	Ana	•	Board		. Balti	more	Street	-
			262 Parti Enter	the disease of con	wolications wat or	used the death	Balti	more	MD such as	2120 s cardiac)] or respiratory	arrest.		Approxima Interval Be	ite
	Br. Marian		shock, or he	the disease, or cor art failure. List onl	y one cause on ea	ach line.			g,		,		į	Interval Be Onset and	beath
\}~	Physician /Medical		Immediate Cause	(Final	_/	0010 4	TION	1.4) !!	Λ		1		
	Examiner		disease or conditi resulting in death)	on	a/T				ea m	01011	4				
		ē			1	45 PHA	s a consequence o	и).					- (
	uted d ansit	Examiner			b. 40	Due to (or a	e e consequence c	if):						<u> </u>	
Ć,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Exa	Sequentially list c if any, leading to i cause. Enter Und Cause (Disease o that initiated even	onditions, immediate	1	EFT O	FREBR	21/15	2011	10	Aras	A ENT	-		
68760,	e be rsicia e bur	cai	Cause (Disease of that initiated even	er injury	c	Due to (or as	a consequence o	OVAL fi:	SUL	MIC	FJOOT	Der			
.89	ificati g phy as th	Medicai	resulting in death)	Last		200 10 (0. 20		.,.					İ		
Вох	nding use				d										
ă	d for]Cia	Part II Other eign	ificent conditions	contributing to de	ath but not resulti	ng in the underlying	a cause a	iven in Part	l.	23b. Dio	d tobecco use c	ontribute	to the ceuse	of death?
P.0	that the death cer ed by the attendin detached for use	Physician/	raitii. Other aigh	moont conditions	contributing to co	attrout not room.	· · · · · · · · · · · · · · · · · · ·	, <u>,</u>				Yes 2 No		obably 4	
	that ned b	by P													
of Vital Records,	w requires that been signed to should be deta	d b										s an autopsy	24b. V	Vere autopsy vailable prior	findings
Ö	req beer shou	iete									рег	formed?	C	ompletion of f death?	cause
Re	elaw has ge 2	Completed									10	Yes 20 No			1No
a	ician: The certificate h rector, page								OC Disc	(D)					
<u>×</u>	Physician: this certific ral director,	Be	25. Was case refe examiner?		Hospital:	u . a⊟rr		0			h (Check only	sidence 6 🗘 O	that /Cnas	Agover 1	nonVa
o	this ral di	2	1 ☐ Yes 2 € 27. Mapper of Dea	No ath	101		R/Outpatient 3□ Bb. Time of	DOA	4 🗆 1			e how injury occu		MIDSOLI C	-(0)109
2	Jing F h. After tuner	io.	Natural	5 Pending		of Injury h, Day Year)	Injury M	28c. Inju Wo	ork?]Yes 2□	No					
Sign	Attending or death. ector: After by the func	icat	2 ☐ Accident 3 ☐ Suicide	investigati 6 □ Could not	be on Bless	of Injury - At home	e, farm, street, fact				28f. Location	(Street and Nun	nber or Ru	ral Route Nut	mber,
Division	or At after of Direction by	Certification:	4 🗆 Homicide	determine	d 200. Place buildir	ng, etc. (Specify)	e, iaiiii, stieet, iaci	ory, office	,		City or T	own, State)			
	urs a	ပိ	29a. Certifier	ette Constitution I	Noveleten. To the	hank of my lenguile	edge, death occurr	and at the t	imo dato a	nd place	and due to th	a causa(s) and n	nanner as	stated	
	To the Hospital or Attending Physician: The liwithin 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only one)	2 Medical Exa	rnysician: 10 the ba aminer: On the ba	sis of examination	and/or investigati	ion, in my	opinion, de	ath occur	red at the time	e, date and place	, and due	to the cause	(s)
	within 2 To the comple	Mec	29b. Signature an	d title of certifier	and mail	.c. otatou.		29c. Licer	se number			29d. Date sign	ed (Month	, Day, Year)	
	5 × 5 8		100	10 V2- 1	1	_	j					-7 -	26-	ME	
			- u	and	mu	0		DLS	450	_		1-6	-6-	00	
		١.	30. Name and add	dress of person wh	o dompleted caus	e of death (Item 2	3a) (Type, Print)	E.	7700	0-	Sor-	7-2	TATICE	a) M	D7578
			WHZZ	EIS H	ETNE	gistrar's Signatur	1200	C+	JUITA	(4)	-15,6	~>0 /	UUCA	ر در در	, 500
	Sta		31. Date filed (Mo	AUG n	2005	gistrar's Signatur	1/2 Sugar								
	Regist	al			2000	MINE A	- Marie								

Registrar DHMH 16 Rev 6/95

	1	For State Registrar	`	Jiaie Oi	i wai yidi	nd / Depa <i>Cei</i>	tificat			ariu iV	ieniai H	ygier Reg. f		05	251.61
ysiciar	1	Decedent's Name (First, Middle DENTITON DATE: DAG									2. Date of D Month	eath	Day	Year	3. Time of Death 12:55 A
Medica	1 -	BENTON BERNARD PAC		eet and num	ahar)		4h Cih	Tour	I anatina -	4 D 41	AUG	0	2 2	2005	
amine	r	STELLA MARIS	, giv a sii	eer and mun	iber)		-	MONIU	Location o	t Death		1	4c. County BALT	of Death	
eral ector		5. Social Security Number 217–80–1172	6. Sex 1 X] N	/ 2□F	7. Age (In yrs. 44	. last birthday) Yrs.	If Under Months	1 Year Days	If Under : Hours	24 Hrs. Min.	8. Date of B (Month, D AUG 19	ay, Yea	50	9. Birth Cor MARY	place (State or Foreigntry)
	- 1-	Usual Residence of Decedent 10a. State 10b. County			10c Ci	ity, Town or Lo	antion					,		12001	
natified at		MARYLAND NA			100.01		IMORE								10d. Inside City Limit 1X Yes 2 □ N
Director	ם ב	10e. Street and Number				ורונאנו	10f. Zip	Code	-	-		10g. C	Citizen of V	Vhat Co	
ad la	2	2303 KOKO LANE						212	l 6				USA		
miner must		11. Marital Status		. Was Deced	dent Ever in U	J.S. 13. V	Vas Deced	lent of Hi	spanic Orig	gin? (Sp	ecify Yes or N Rican, etc.)	0-	14. Rac	e - Amer	ican Indian,
Mical Examinaring		1 Never Married 2 Marri 3 Widowed 4 Divorced	ed	1 ☐ Yes :	9		☐ Yes :		Specify:	,			Specify	k, White AFR	
1 To		15. Decedent	's Educat	Year or Da		16a. Deced	ent's Heus	I Occup:	ation			165		AMER	ICAN
t, the water to	2	(Specify only highes Elementary/Secondary (0-12)	t grade d	completed) College (1-	/or 5+\	(Give	kind of wor OO NOT us	k done d	luring most	of work	ing	100.	Kind of Bu	ısıness/ii	ndustry
at l	5	12		2	401 347	SAI	ESMAN					F	ПМ		
avant		17. Father's Name (First, Middle, L	,								(First, Middle	, Maide	en Surnam	10)	
P	-	SYLVESTER S. PACE S		0-1-4		1					SE PACE				
Department of realin and wental Hygene. Important: If item 27 is marked other than any injury or other traumatic avant, ite Magne. To Be Compl		19a. Informant's Name/Relationsh STEVIE J. SPENCER		ROTHER		2303	g Address KOKO I	(Strøet a ANE	BALTIM	r or Rura 10RE,	A Route Numb MARYLAN	pe <i>r, City</i> D 2]	or Town, L216	State, Zi	o Code)
	1	20a. Method of Disposition			1 -	Place of Dispos	sition (Nan	ne of			ate			City or T	own, State
	1	1 Burial 2 □ Cremation Cremation 5 □ Other (Sp		noval from S		zemetery, cren ZION CE		пөг ріасі	I	IG 6.	2005	LANS	SDOWNE	. MAR	YT.AND
		21. Signature of Funeral Service L	icensee			22	Name and	d Addres	s of Facility	,	LE FUNERA				
	1	Sumerla	Hone			638	N. GI	LMOR	STREET	BAI	TIMORE.	MARY			
		23a. Part1. Enter the disease, or of shock, or heart failure. List of the control of the cont	omplica only one	tions that ca ca <i>u</i> se on ea	used the deat ch line.	h. Do not ente	er the mode	of dying	, such as o	ardiac c	r respiratory a	rrest,			Approximate Interval Between
an al		Immediate Cause (Final disease or condition resulting in death)	_ a. 1	1ETAST	IC SQU	AMOUS (TITT T	CANC	ER OF	тнь	ANTIC				Onset and Death
er			ar	Due to (o			ا بابلتان	OZHIO	DIC OF	TILL	AMOD				
	.				r as a conseq	uence of):	ا بليليان	OI III O	DIC OI		MOD			1	
e l		Sequentially list conditions any, leading to immediate	b	Due to (o	or as a conseq	uence of):	ا باباظ	ornvo	DK OI	I	ANOS				
aminer		Sequentially list conditions any, leading to immediate bause. Enter Underlying Cause (Disease or injury hat initiated events	b	Due to (o		uence of):	ا باداظ	<u> </u>			ANOS				
ũ		r any, leading to immediate cause. Enter Underlying Cause (Disease or injury				uence of):	ا بلدانان			111	ANOD				
Ä		r any, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events			or as a conseq	uence of):	ا بادایان				ANUU				
ŭ		i any, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last	c	Due to (o	or as a conseq	uence of): uence of):	iBlab (ANOS		and Date		
ЩX		riany, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last F FEMALE: 23b. Was decedent pregnant in the past 12 months?	c	Due to (o	or as a conseq	uence of): uence of): uence of): ancy I death 3 □	Ectopic pre	egnancy			ANOS		23d. Date Mon		ery Day Year
clan/Medical Ex		is any, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c	Due to (o	or as a consequence or as a consequence of pregnath 2 Feta nt at time of divin	uence of): uence of): uence of): ancy death 3 = eath 5 =	Ectopic pre Other (spe	egnancy ecify)			ANOS				,
by Physician/Medical Ex	F	is any, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	c	Due to (o	or as a consequence or as a consequence of pregnath 2 Feta nt at time of divin	uence of): uence of): uence of): ancy d death 3 = eath 5 =	Ectopic pre Other (spe	egnancy ecify)				obacco	Mon	ibute to t	Day Year
by Physician/Medical Ex	F	is any, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c	Due to (o	or as a consequence or as a consequence of pregnath 2 Feta nt at time of divin	uence of): uence of): uence of): ancy d death 3 = eath 5 =	Ectopic pre Other (spe	egnancy ecify)			23e. Did t	obacco Yes 2	Mon	ibute to t	Day Year
by Physician/Medical Ex	F	is any, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c	Due to (o	or as a consequence or as a consequence of pregnath 2 Feta nt at time of divin	uence of): uence of): uence of): ancy d death 3 = eath 5 =	Ectopic pre Other (spe	egnancy ecify)			23e. Did t	Yes 2 an psy	Monuse contri	ibute to to	Day Year
Completed by Physician/Medical Ex	F	in any, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c	Due to (o	or as a consequence or as a consequence of pregnath 2 Feta nt at time of divin	uence of): uence of): uence of): ancy d death 3 = eath 5 =	Ectopic pre Other (spe	egnancy ecify)			23e. Did t	Yes 2	use contri	ibute to t	Day Year ne cause of death? nably 4 Unknown psy findings available mpletion of cause of
Be Completed by Physician/Medical Ex	F	is any, leading to immulate cause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant conditions.	d23c.	Due to (o	or as a consequence of pregnath 2 Feta time of dwn	uence of): uence of): uence of): ancy I death 3 = eath 5 = ulting in the un	Ectopic pre Other (spe derlying ca	egnancy cify) use give	n in Part I. 26. Place (of Death	23e. Did t 1	Yes 2 an psy prmed? 2 No	Monuse contribution with the contribution wi	ibute to to the state of the st	Day Year ne cause of death? pably 4 Vunknown psy findings available mpletion of cause of 2 \(\square\$ No
To Be Completed by Physician/Medical Ex	F - 2	is any, leading to immulate cause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	cd23c.	Due to (o	or as a consequence or as a consequence of pregnath 2 Feta nt at time of divin	uence of): uence or): uence of): uence of): ancy death 3 = eath 5 = utility utting in the un ER/Outpatient 28b. Time of	Ectopic pre Other (spe derlying ca	egnancy ecify) use give	n in Part I. 26. Place 7. 4 □ Nur:	of Death sing Hon	23e. Did to the second of the	an psy primed? 2 Noone) dence	Mon use contri 2 \(\text{No} \) 24b. W pl dd o 1 6 \(\text{X} \) Othe	bute to to a substitute of the	Day Year ne cause of death? pably 4 Vunknown psy findings available mpletion of cause of 2 \(\square\$ No
To Be Completed by Physician/Medical Ex	F - 2	is any, leading to immulate cause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant condition art II. Other significant conditions.	c	Due to (o	or as a consequence of pregnath 2 Feta time of diversity at the but not result patient 2 Feta pa	uence of): uence of): uence of): ancy I death 3 eath 5 ulting in the un	Ectopic pre Other (spe derlying ca	egnancy scify) use give	n in Part I. 26. Place 7. 4 □ Nur:	of Death sing Hon	23e. Did t 1	an psy primed? 2 Noone) dence	Mon use contri 2 \(\text{No} \) 24b. W pl dd o 1 6 \(\text{X} \) Othe	bute to to a substitute of the	Day Year ne cause of death? nably 4 **TUnknown psy findings available mpletion of cause of 2 \sum No
rtification: To Be Completed by Physician/Medical Ex	F - 2	is any, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition are a manner? 1 Yes 2 No 9 Was case referred to medical examiner? 1 Yes 2 No 7. Manner of Death 1 Natural 5 Pending	d23c.	Due to (o If yes, outcut Live bin 4 Pregnat 9 Unknow buting to dea pital: 1 Inp. 28a. Date of (Month,	or as a consequence of pregnation of pregnation of pregnation of distribution	uence of): uence of): uence of): uence of): uence of): uting in the un ER/Outpatient 28b. Time of Injury	Ectopic prediction of the control of	egnancy ecify)	n in Part I. 26. Place of 4 □ Nursat	of Death sing Hon 2	23e. Did 1 1	an psy primed? 2 None) dence how inju	Monuse contribution with the second s	inth ibute to to to 3 Protection to coeath? Yes	Day Year ne cause of death? nably 4 **TUnknown psy findings available mpletion of cause of 2 \sum No
n by the funeral director, page 2 should be detached for use as the burial- rtification: To Be Completed by Physician/Medical Ex	F - 2	is any, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d23c.	Due to (o If yes, outcome to the bird to the bird to deal to the bird to deal to the bird to deal to the bird to deal to the bird to deal to the bird	or as a consequence of pregnath 2 Feta nt at time of diversity at hour results of the patient 2 Injury Pay Year)	uence of): uence	Ectopic pre Other (spe derlying ca	egnancy cify)	n in Part I. 26. Place of the State of the	of Death sing Hon 2 0	23e. Did to the control of the contr	Yes 2 an psy primed? 2 None) dence how inju	Monuse contribution use contribution of the co	ibute to to to a superior to coeath? or (Specified)	Day Year The cause of death?
refileration: To Be Completed by Physician/Medical Ex	F 2	is any, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d23c.	Due to (o If yes, outcome to the bird to the bird to deal to the bird to deal to the bird to deal to the bird to deal to the bird to deal to the bird	or as a consequence of pregnath 2 Feta nt at time of diwn patient 2 Injury Day Year) Injury At hog, etc. (Specify east of my knows of examinal	uence of): uence	Ectopic prediction of the control of	egnancy cify) use give a Othe c. Injury Work 1 Y	n in Part I. 26. Place of the second of the	of Death sing Hon 2 0	23e. Did to the control of the contr	Yes 2 an psy prmed? 2 No pne) dence how inju Street a wn, State cause(s date an	Monuse contribution with the second of the s	ibute to to to a library for autorior to coeath? If yes are (Specified and a ror Rura) for Rura, and a sind due to the state of the st	Day Year ne cause of death? ne cause of death? ne cause of death? ne cause of death? Ne pably 4 **TUnknown psy findings available mpletion of cause of 2 **D No **P HOSPICE If Route Number, ated. the cause(s)
ed in by the funeral director, page 2 should be detached for use as the burial- Certification: To Be Completed by Physician/Medical Ex	F 2	is any, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d23c.	Due to (o If yes, outcome to the best of	or as a consequence of pregnath 2 Feta nt at time of diwn patient 2 Injury Day Year) Injury At hog, etc. (Specify east of my knows of examinal	uence of): uence	Ectopic prediction of the control of	ognancy scify)	n in Part I. 26. Place of the second of the	of Death sing Hon 2 o 2	23e. Did to the control of the contr	Yes 2 an psy prmed? 2 No pne) dence how inju Street a wn, State cause(s date an	Monuse contribution with the second of the s	ibute to to to a some control of the	Day Year The cause of death?

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

AUG 0 4 2005

State Registrar 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093
32 Registrar's Signature

			For State Registrar		State of I	Marylan		artment			and M	lental Hyg	giene Reg. No	200	5	256	65
	Physici	an	1. Decedent's Name			1105						2. Date of Dea	Day		ear	3. Time of	Death A M
4	/Medic Examin		4a. Fecility Name (If		give street and number	US5		4b. City,	Town, or	Location o	f Death	August		County of	Death	0:00) A
1	Exami	ei			dical Cent			Annap					1 .	ne Ai		le1	
	Funeral Director		5. Social Security Nu 289-32-30		6. Sex 7. 1 ☐ M 2 ☐ F	Age (In yrs.	last birthday) 68 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 4-27-1	r, Year)	9 I	Birthp Coun ayt	lace (State o	r Foreign 1
	and		Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	ty, Town or Lo	cation							1-	0d. Inside Ci	ty Limits
	Maryl f sho	tor	MD	Anne A	runde1	Anr	napolis	3								1 ∑ Yes	-
	r 28a	irec	10e. Street and Num	ber				10f. Zip	Code				10g. Citi	izen of Wha	at Coun	ntry?	
	th wit	aiD	1719 Old	Genera	ls Highway			21	401				U.S	S.A.			
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Itame 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed	**	12. Was Deceded Armed Force 1 Tyes 2 If Yes, Give Year or Date	ss? Mano		Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spo , Puerto	ecify Yes or No- Rican, etc.)		14. Race - Black, Specify:	White,	etc.	
Maryland 21215-0036	n 72 ho "natu	Completed	(Speci		s Education grade completed)		16a. Dece	dent's Usua kind of wor DO NOT us	l Occupa k done d e retired	tion uring most	of work	ing	16b. Ki	ind of Busin	ness/Ind	dustry	
212	d within giene.	omo	Elementary/Secon	ndary (0-12)	College (1-4	or 5+)	Homen						Ow	n Hon	ne		
nd	be filed ntal Hygi od other event,	Be	17. Father's Name ((First, Middle,	Maiden	Sumame)			
<u>Ş</u>	should bind Ment marked umatic e	10	Robert V	-			19h Mailir	an Address	(Street 2	-		tickel al Route Numbe	r City o	r Town St	ata Zin	Code	
Ma	nd 2 shoulth and 27 le m				/ Husband		1	•				hway, A			MD		01
Je,	s 1 and 2 of Health a litem 27 le		20a. Method of Disp	osition		20b. F	Place of Dispo cemetery, crei	sition (Nam	e of ther place) .		Date	20c. Lo	cation - Ci	ty or To	wn, State	
Ë	Page ment cant: if ant: if		4 Donation		3 Removal from Sta	Ar	lingtor			, ;				kvi11			
Baltimore,	permit. Pages. Depertment of H Important: if Ite any injury or of		21. Signature of Fur	neral Service L	pulle							ngleton en Burn			Hom 2106		
			23a. Part1. Enter th shock, or hear	e disease, or o t failure. List o	complications that cause on each	sed the deat h line.	h. Do not ent	er the mode	of dying	, such as	cardiac o	or respiratory ari	rest,			Approximate Interval Bets Onset and I	ween
Î	Physician /Medical		Immediate Cause (F disease or condition resulting in death)	Final 1	a. CA	RPIA	e Hr	rry	Thr	na							
	Examiner					as a conseq	uence of):										
	p tis	iner	Sequentially list con if any, leading to instruction. Enter Under Cause (Disease or in	ditions, mediate tying	b. — Due to (or	as a conseq	uence of).										
_	xecute and II-trans	Examiner	that initiated events resulting in death) L		c. Due to (or	as a conseq	uence of):								-		-
8760,	certificate be executed rding physicien and use as the burial-transit	licai E			d.												
9	rtificat ng phy as th	Aedi	IE EEMALE.										- 1		J.		
P.O. Box	death e atter id for u	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 to 1 ☐ Yes 2 € 9 ☐ Unknown	months?	23c. If yes, outcor 1 □ Live birth 4 □ Pregnan 9 □ Unknow	n 2 ∏ Feta tat time of d	ıldeath 3[Ectopic pre Other (spe						23d. Date of Month		*	/ear
	sign d be	þ	Part II. Other signification	cant condition	ns contributing to deat	h but not res	ulting in the u	nderlying ca	tuse give	n in Part I.		23e. Did to				necauseofd ably 4 ∐L	
Vital Records,	The ate h	Completed					_					24a. Was a autopo perfor 1 🗆 Yes	sy	prio dea	r to con th?	psy findings and pletion of ca	available ause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referre		Hospital:				Othe		of Death	Check only or	n <i>e)</i>				
o o	Phys this ral dii	7.	1 Yes 2 1		1 Linps		ER/Outpatier 28b. Time of		A	4 U Nui	-	me 5 Resid			(Specify	/)	
ion	Attending Phr r death. actor: After th by the funeral	ation	1	5 Pending investiga		Day Year)	Injury	м	8c. Injury Work 1 □ Y	? ′es 2.∐1			,_	,			
Division	A C S S	Certification:	3 Suicide 4 Homicide	6 Could no determin	ned 286. Place of	Injury - At he etc. (Specif		eet, factory	, office			28f. Location (S City or Tow	treet an n, State	d Number)	or Rura	l Route Num.	ber,
		dicai	29a. Certifier (Check only one)	1 \ Certifying 2	Physician: To the be xaminer: On the basis and manner	s of examina	wledge, deatl ttion and/or in	occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, th occurr	and due to the c ed at the time, o	ause(s)	and mann I place, and	er as st d due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and	title of certifier	0)				. License					e signed (/			
	7		30. Name and addre	Bish ess of person w	no completed cause of	2 H of all ath (Item) n 23a) (Type,	Print)	218	529	-87	tunop	Re	ughe	7.	2, 56	05
	0		31. Date filed (Month	b Day Your	D, 2009	istrar's Signa	ETER.	Cilo	13_	DR.	1_Y	tunog	Clis	,01	レニ	21401	1
	Sta Registr		OT. Date med (WORK		1 2005		aturo,	_				•					
DH	MH 17 Rev 1/2			HUU V	2 20001	RELIGIA.	~ 1	-									

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

							ertifica		Death		Reg. No?	0.5	25466
	Physici	an	1. Decedent's Name (First, Middle, La							2. Date of De Month	Day	Year	3. Time of Death
-	/Medi	cal	Frances Cecilia Rev		ner)				4b. City, Town, or	August		y of Dogth	1: dopar
	Examir	ıer	Hart Heritage Estate /						Street		Harfor		,
	Funeral Director		214-01-2839	ex □м 2 X XF	Age (In yrs. 89	last birtho	Month	er 1 Year Days	If Under 24 Hrs Hours Min.	8. Date of Bi	2, 1915	9. Birthi Mar	place (State or Foreign "Yland
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town o	r Location					1.	10d. Inside City Limits
	Mery e-f sh	ţo	Maryland Baltimore	9	Ba	ltimor	e						1 ☐ Yes 2 💢 No
	th with the 23a or 28 unt be no	ral Dire	10e. Street and Number 1749 Forrest Avenue					ip Code 21234			10g. Citizen of USA	What Coul	ntry?
020	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Meryland Depertment of Health end Mentel Hygiene. Important: if item 27 is merked other than "natural", or items 23a or 28e-f show entry injury or other treumatic event, the Medical Exacioner must be redilled at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ₩ idowed 4 □ Divorced	12. Was Deced Armed Forc 1 Yes 2 If Yes, Give Year or Date	IX No	J,S.		edent of Fecify Cub 2 No	Hispanic Origin? (S an, Mexicen, Puer Specify:	pecify Yes or No to Rican, etc.)	14. Rad Bla Specif	ck, White,	can Indian, etc. ite
Maryland 21215-0020	in 72 h	ojetec	15. Decedent's Ed (Specify only highest gra	de completed)		16a. De (G	cedent's Us ive kind of v e. DO NOT	ual Occup ork done use retire	oation during most of wo d)	rking	16b. Kind of B	usiness/In	dustry
212	d with giene.	Com	Elementary/Secondary (0-12)	College (1-4	or 5+)	Secr	etary				U.S. Gove	ernmen	t
pu	be file tel Hy d othe	3e	17. Father's Name (First, Middle, Lest)								, Maiden Surnar		
ryla	d Men	To	Frederick Garrison 19a. Informant's Name/Relationship (Euro Deinel		40h 14	atita - A dala	/04	Catherin	e F. Sope		0-1 7	0.41
Ma	alth en 27 is r r treur		Carol Raynor/Great Nie	• • • •					ad Glen Ar				o Code)
Baltimore,	Pages 1 a nent of He ant: if item ury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from St	20b. I	prelanc	sposition (Notematory of Mem.	other pla Park		Date 8/6/05	20c. Location Baltimor	re Mary	
Balt	Thus was OX. Auton 5305 Hartord Road									ltimore Ma	aryland 2	21214	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that cau one cause on eac	sed the deat h line.	th. Do not	enter the m	de of dyir	ng, such as cardia	or respiratory a	rrest,		Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final		A	ND	Stas	0 -	Dementi	A		! !	years
	Examiner	_	disease or condition resulting in death)	a			sequence o					1	y-w.r.
	ed sit	iner	_	b									
	el-tran	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or as a con	scquence d):				1	
68760,	ntificete be executed ing physicien end es the buriel-transit		that initiated events	c	Due to (c	or as a cons	sequence of):	•				
89 x	entifice ling ph e es th	Medical	resulting in death) Last	d								į	
Вох	eath ce attendii for use	clan/		d						T. C.		1	
P.O.	that the death ed by the atte detached for	Physician/	Part II. Other significant conditions of	ontributing to deat	h but not res	ulting in th	e underlying	cause giv	en in Part I.				the cause of death? bably 4 ⊠ Unknown
S, P	es that igned t	2	VA 180 - 180 - A 1 A 1 A 1 B 1 B 1 A 1 A 1 A 1 B 1 A 1 A									00,70	Jacon Jacon Line
of Vital Records,	aw requir ss been s 2 should	Completed									an autopsy ormed?	av	ere autopsy findings ailable prior to mpletion of cause death?
Œ	Page Page Page Page Page Page Page Page								10	Yes 2 Duc	10	☐Yes 2☐No	
Vita	ician: The certificete rector, pag	Be	25. Was cese referred to medical examiner?	Hospital:				Oth	or:	ath (Check only o	-		Assested
on of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification pleepy filled in by the funeral director,	ition: To	1 Yes 2 16 27. Manner of Deeth 1 Naturel 5 Pending investigation	1 □ Inp 28a. Date of (Month,	atient 2□ Injury Dey Year)	28b. Time Injur	e of	28c. Injur Wor	4 Li Nursing F		dence 6 Both how injury occur		V) CARL
Division	al or Atten s after dea i Director d in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of	Injury - At h etc. (Specif	ome, farm, y)	street, facto	ry, office		28f. Location (City or To		er or Rura	al Route Number,
	Hospit 24 hour Funera stely fills	edical (29a. Certifier (Check only one) 12 Certifying Ph	/sician: To the be Iner: On the basi end manner	s of examina	wledge, de tion and/or	ath occurre investigation	d at the tin	ne, date and place pinion, death occu	, and due to the rred et the time,	cause(s) and ma date and place,	inner as st	tated. o the cause(s)
	ro the within To the	Mec					2	9c. Licens	e number		29d. Date signe	d (Month,	Day, Year)
	/		► An As	1 MD				D	39889		Aug i	rs+	3,2005
	12		30. Name end eddress of person who declared to the second	completed ceuse of	of deeth (Item	n 23a) (Typ	oe, Print) Bel/	Ain	MD	210	4		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Reg	rar's Signa	ature &	Ace	de					

			Please	-		onartment of		•	•	
			for State Registrar	State of Ma	aryland / i	Department of I Certificate of			2000	251.67
			Registrar 1. Decedent's Name (First, Middle, La	ast)	-	Gertificate of	Death	2. Date of Deat	3.110.	3. Time of Death
	Physici			P. RICHT	MOND			JULY	Day Year	OU DEL
	/Medi Examir		4a. Facility Name (If not institution, gir	ve street and number)		4b. City, Town,	or Location of Death		4c. County of Dear)
			UNIVERCITY OF N	ARXIANA	REDICAL	B GARLEN	AUTMOR	E	Baltimore	e
	Funeral		Social Security Number 6.5	Sex 7. Ag	e (In yrs. last bi	rthday) If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Year) 9. Bin	thplace (State or Foreign puntry)
	Director		Usual Residence of Decedent		14	113.		JONE,	27, 1311 Rho	de Island
	yland		10a. State 10b. County		10c. City, Tow		_			10d. Inside City Limits
	e Ma	ctor	Montgome Montgome	ery	SILV	FRSPRIN	9			1 ☐ Yes 2 No
	or 26	Director	10e. Street and Number	FIELD R	H	10f. Zip Code	20904	10	g. Citizen of What Co	•
	72 hours after death with the Maryland natural', or Items 23a or 28a-1 ehow dreal Examber outlied ut	erai		12. Was Decedent			(- (posity Vos or No	14. Race - Ame	
,	fter d	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?		13. Was Decedent of If Yes, specify Cub		Rican, etc.)	Black, Whit	
036	al', o	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: Wh:	ite
2-0	d within 72 hours i jiene. r than "natural", (the wedical Exal	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of work	king	6b. Kind of Business/	
121	- 365	mpi	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Claims Ma		1	Insurance	
d 2	Hyg Hyg othe		17. Father's Name (First, Middle, Last	•				e (First, Middle, N		
lan	e d ita	To Be	Russell Richmond				Grace	Pierce		
Maryland 21215-0036	d 2 should th and Men 7 Is marke traumatic		19a. Informant's Name/Relationship		196	. Mailing Address (Stree	t and Number or Rui	ral Route Number,	City or Town, State, 2	Zip Code)
	C = 01 -			Daughter)		19900 Pine		Drinklo		
ore	Pages 1 are neut of Hear int: It Item		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	☐Removal from State	1	f Disposition (Name of ry, crematory or other pla			0c. Location - City or	
Baltimore,			* 4 □ Donation 5 □ Other (Specia	-	-	Point Cemet			Providence	, RI
Ba	permit. Departr Imports any inje		21. Signature of Funeral Service Lice	Pa 1.10	#CC0321	22. Name and Addr Goodwin Fu 607 Chestr	neral Hon	ie Ianahaata	- NII 0210	
			23a. Part1. Enter the disease, or comshock, or hear fallurg. List only	iplications that caused	the death. Do					Approximate Interval Between
	Enysician		Immediate Cause (Final disease or condition	0.		LMONAR		REFT		Onset and Death
	/Medical		resulting in death)		a consequence		7 71	(cer)		
	Examiner		Sequentially list conditions,	b. 13 U	UNT	CARDIA	c int	URY.	\Box	
	ped nsit	nine	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	on.			M	
Ø,092	eath certificate be executed attending physician and for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence	of):		12	16	
192	ysicia	cal		_ d				12N		
89	death certifica e attending ph od for use as th	Physician/Med	IF FEMALE:				-/-	_/		
Вох	ath ce	ian/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal death		y C		23d. Date of deli Month	ivery Day Year
P.O.	O O	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 Other (specify)				,
	requires that the death een signed by the atter hould be detached for t	by Ph	Part II. Other significant conditions	contributing to death b	ut not resulting in	n the underlying cause gr	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Records,	w requires been sign should be							1 🗆 Yes	2 2 No 3 □ Pro	obably 4 Unknown
900	S S S	Completed						24a. Was an	24b. Were au	topsy findings available
Ä	The law ate has b page 2 s	Com						perform		2 No
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hagnitali		04		h (Check only one)	
of	d is	. To	1 XYes 2 No 27. Manner of Death	Hospital: 1 Inpatie		Itpatient 3 DOA		ome 5 Resider	nce 6 Other (Spec	cify)
OU	ling After lune	tion	1 □ Natural 5 □ Pending 2 ■ Accident investigatio	(Month, Day	Year)	njury Wo		Frontse		NGE!
Division	Attending or death. ector: After by the fune	ifica	3 Suicide 6 Could not b	28e. Place of Inju	ury - At home, fa	rm, street, factory, office	-	28f. Location (Str	eet and Number or Ru	ral Route Number,
Ö	s afte	Certification:	4 Homicide	building, etc	c. (Specify)	"OADWA	- V	Ramo IC	out Ros	to 170
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier 1 Certifying Pt	nysicien: To the best of	of my knowledge	dor investigation, in my	me, date and place,	and due to the car	use(s) and manner as	stated to the cause(s)
	the hin 24 the F	Medi	29b. Signature and title of certifier	and manner sta	ited.	29c. Licens			d. Date signed (Month	
	Z iš Z S		ADO		1	250. Elbert		23	distre	•
	10	~	30. Name and address of person who	completed cause of de	eath (Item 23a)	(Type, Print)			1111103	
	Ψ		SHYAMASUND			MANTA	22 South	6 Greeni	St Ball	V, KD
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	not c				
	Registr	a!	AUG 0 4 2005	ALBERT .	JU A					

DHMH 17 Rev 1/2001

	ĺ	State of Maryland / Der 1- State of Maryland / D	partment of Health and Me 1/21 05 CC Frifficate of Death	ental Hygi	ene 2005 25468
Dhysisis		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
Physicia /Medic	al	Lewis E Ray			, 2005 10:20P ^M
Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
Funeral		Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Silver Spring y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgomery 9. Birthplace (State or Foreign
Director		217-32-0245 1M 2□F 69 Yrs.	Months Days Hours Min.	(Month, Day, Aug. 11	Year) Country) , 1935 MARYLAND
pu 👔 🗈		Usual Residence of Decedent 10a. State 10 10b. County Hampshire 10c. City, Town or	ocation		10d. Inside City Limits
Aaryla f sho	ō	Hampsnire	Augusta		Yes Z
the h	Director	Maryland Prince George's Laurer 10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
h with	ie D	16004 Kenny Road RFD 1 Box 68	-20707 2670497	22 U	nited States
Si si si si si si si si si si si si si si	by Funerai	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 No 1953 If Yes, Give Year or Dates: 1955	Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto R □ Yes 2 ▼ No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
5-0	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation ve kind of work done during most of working	g 1	6b. Kind of Business/Industry
within sene.	щ	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		Taunder Maka
d 2 filed v Hygie thert		6 E	lectrician 18. Mother's Name	(First, Middle, M	Laundry Mats aiden Sumame
and be de de de de de de de de de de de de de	To Be	Golden L. Ray	Lillian		,
Maryland 2121: d 2 should be filed within th and Mental Hygiene. It is marked other than "treumatic event, the Mes	F		iling Address (Street and Number or Rural	Route Number,	City or Town, State, Zip Code)
1 and 2 1 and 2 Health a 1 em 27 is			McKown Dr., Fallin	Waters	s, WV 25419
0 0 0		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition	position (Name of Parameter)	ite 2	Oc. Location - City or Town, State
Pages Pages ment of lent: If it		`4 □Donation 5 □Other (Specify) Ft. Linc	oln Cemetery 7/26		Brentwood, MD
Baltime permit. Pag Department Importent: I any injury o		Mancy a Bossette R	22. Name and Address of Facility Gif. te. 50 West, Capon 1	Bridge,	WV 26711
Physician /Medical Examiner physician and physician and physician and the printlement the printlement physician and physician an	ai Examiner	23a. Part 1. Enter the disea each of complications that caused the death. Do not eashbook, or hear if it in a shock, or he			Onset and Death
Box 687 death certificate e attending physical for use as the	Physician/Medical		: □Ectopic pregnancy : □ Other (specify)		23d. Date of delivery Month Day Year
S, esth	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to the cause of death? s 2 ☑ No 3 ☐ Probably 4 ☐Unknown
The The page	Completed			24a. Was an autopsy perform	prior to completion of cause of
of Vital Physicien: T this certificate ral director, pe	Be	25. Was case referred to medical examiner?	26. Place of Death		
hys hys	P.	1 ☐ Yes 2X No Hospital: 1 1 Inpatient 2 ☐ ER/Outpate 27. Manner of Death 28a. Date of Injury 28b. Time	all 3 DOA 4 DIAGISING HOIN		nce 6 Other (Specify) v injury occurred
June tune	tion	1 XNatural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation			,,,
Division or Attending after death. Director: After	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office 28	3f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
Division To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deadless of examination and/or and manner stated.			
To th within To th	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month, Day, Year)
		Padrada the M.D.	D0060038		07/22/05
12		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)		eter Mark to a rest Moreover
12		Padmalatha R. Moole, MD, 1500 Fores	st Glen Road, Silver	Spring	, MD 20910
Stat Registra	-	AUG 0 4 2005	de la companya della companya della companya de la companya della		

DHMH 17 Rev 1/2001

ORIGINAL

within 24 hours et To the Funeral D

1 State

Pamela E. Southell, MD 31. Date liled (Month, Day, Year) AUG 0 4 2005

29b. Signature and title of certifier

Registrar's Signature conti

DUMMULL. MU) 30. Name and address of person who completed cause of death (item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

29c. License number

OCME

111 PENN STREET, BALTIMORE, MARYLAND, 21201

29d. Date signed (Month, Day, Year)

JULY 29, 2005

			1 - For State Registrar	State of Maryla	and / Depa		of He	ealth a		•	_)5 9E	:1.70
	Physic /Medi	cal	Decedent's Name (First, Middle, Lass George Rogers Office Rogers Office Rogers Office Rogers Office Rogers Office Rogers Office Rogers							2. Date of De Month	19, 20	Year 05 0	45 p M
	Examir Funeral	ner	5. Social Security Number 6. Se	reral 405	pital rs. last birthday)	Ball 7	Year	Location o	24 Hrs.	8. Date of Bir	4c. Count		State or Foreign
	Director		220-86-3247 Usual Residence of Decedent 10a. State 10b. County	3 M 2□ F 44	Yrs. City, Town or Lo		Days	Hours	Min. I	Month, Da Dec 11	, 1960		unk
	a-f sho	tor	MD		Balt								Yes 2 No
	with the	Dire	10e. Street and Number			10f. Zip C		1015			10g. Citizen of		
	ns 23	eral	2525 W. Belveder	e Avenue 12. Was Decedent Ever in	U.S. 13	Was Decede		1215	nin? (Sner	rify Yes or No	USA	ce - American Inc	tian
920	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show ilical Exarnii 8t must be rodified at	by Funeral Director	1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		If Yes, specif		, Mexican, Specify:	, Puerto F	cify Yes or No Rican, etc.)		y: black	, indi.,
21215-0036	filed within 72 ho Hygiene. Ither than "natu	Be Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use	done du	ion <i>iring</i> most	of workin	g unk	16b. Kind of B	usiness/Industry	unk
Maryland 2	d tal	To Be Co	unk u: 17. Father's Name (First, Middle, Last)	nk		ι	ınk			(First, Middle,	, Maiden Sumar ers	пе)	
Mary	12 should h and Men 7 ls marks traumatic		19a. Informant's Name/Relationship (7 Md General Hospit.	•				nd Number	r or Rurai		er, City or Town	State, Zip Code,)
Baltimore, I	Pages 1 and nent of Health int: If Itam 27 iry or other tr		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ '4 □ Donation 5 ☒ Other (Specify	20b	. Place of Dispo cemetery, crer	sition (Name	of	1	Dal			1201 - City or Town, Si	ate
Baltii	permit. F Departm Importar any injur		21. Signature of Funeral Stryice Licens			Name and late Ar		-		655 W.	Baltim	ore Stre	et
	Physician		23a. Pant : Enter the disease, or comp shock or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the de one cause on each line.						respiratory a	rrest,	Interv	eximate val Between t and Death
b	/Medical Examiner			AHICKOSC	equence of):	°C (ad	10 00	SCU	lar	Dise	rse	
	secuted and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to for as a const	equence of):	Hitu	13						
68760,	ficate be executed physician and s the burial-transit	cal	l	d									
P.O. Box (law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic preg Other (spec						te of delivery onth Day	Year
	w requires that been signed b should be deta	b	Part II. Other significant conditions co	ntributing to death but not r	esulting in the u	nderlying cau	se given	in Part I.				ribute to the caus	
Il Records,	The law re ate has be page 2 sho	Completed								24a. Was autop perfo 1 Yes	rmed?	Were autopsy fin- prior to completio death? 1 \(\text{Yes} \(2 \text{ N} \)	n of cause of
of Vital	ı lclan : Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	/		-			Check onl o			
on of	To the Hospital or Attanding Physician: The I within 24 hours after death. To the Funaral Director: After this certificate ha completely filled in by the funeral director, page	tlon; To	1 2 Yes 2 No 27. Manney of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		. Injury a Work?	4 □ Nurs ut es 2 □ N	28		dence 6 Oth		
Division	al or Attandi s after death. si Diractor: A si in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre cify)	eet, factory, c	office		28	8f. Location (S City or Tox	Street and Numb vn, State)	er or Rural Route	Number,
	To the Hospital or Attand within 24 hours after death To the Funeral Director: completely filled in by the	Medical (one)	sician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, death	occurred at restigation, in	the time, my opin	, date and nion, death	l place, ar	d due to the d	cause(s) and ma date and place,	nner as stated. and due to the ca	use(s)
	vithi To the	Σ	29b. Signature and title of certifier			29c. L	icense r	number	_		29d. Date signe	d (Month, Day, Yo	ear)
,			1 Amakin W	Macon M	D	D	15	550	3		July	21,20	005
			30. Name and address of person who c Amu Wallet 31. Date filed (Month, Day, Year)	ompleted cause of death (It	DOPI	um S.	4. E	Balt	inon	e,n	1d. 21	217	
	Sta Registr	- 4	AUG 0 4 2005	Sz. Negistiai s Sig	Annal								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 26 per doc 3846 8-4-05 vt.

Amend item 5 per th 8846 8-10-05 vt.

Reg. No 2 0 0 5 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Year .30 **Physician** 10 tor Jonna 2 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 6845 Boston Avenue Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 🖾 F Yrs. 5.1960 Director 180-54-9469 May <u>Pennsylvania</u> Usual Residence of Decedent with the Maryland 10a, State 10h County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Dundalk Md Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 6845 Boston Avenue 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Items Black, White, etc. filed within 72 hours after Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 2 3 ☐ Widowed 4 ☐ Divorced "natural". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 Is marked other then "na any injury or other traumatic event. Its Wade once. (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) AT & T Manager unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Janina Bosas James Storey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Storey (brother) P.O. Box 106 Mifflin, Pennsylvania 17058 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State Bayview Crematory Aug 4,05 Baltimore, Md * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilly aczorowski Funeral Home, PA 21. Signature of Funeral Sery 1201 Dundalk Ave. Baltimore, Md 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ecvico disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Decause or injury) that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transit requires that the death certificate be executed the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes 1 ☐ Yes Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home X Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2**%**No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident thours after death uneral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital of within 24 hours at To the Funeral D 29a, Certifier 😭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d, Date signed (Month, Dav. Year) 29c. License number 29b. Signature and title of certifier D006201 VD 21287-1281 auto completed cause of death (Item 23a) (Type, Print) and address 600 N. Wolfe St., Phipps Building, Baltimore, Ginger Gardner, M.D. 32. Registrar's Signature State AUG 0 4 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene

		•	1 - State Registrar	State of Marylan	•		ite of De		vicinal riy	Reg. No:	2005	25172	
	Dhusisi		Decedent's Name (First, Middle, Last)	411					2, Date of De Month		Year	Time of Death	
	Physici /Medio		ROBERT	SELBY					JULY	28	, 200		_
	Examin		4a. Facility Name (If not institution, give st			4b. Cit		cation of Death			County of Dea		
				SPITAL		16110	7.1	NORE 1 Under 24 Hrs.	O Data of Bio		BAUTIM	ORE	
r	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	iast birthday) Yrs.	Month		Hours Min.	8. Date of Bir (Month, Da	y, Year)		thplace (State or Foreign ountry)	
	Director	1	218-32-1337 Superior						Sept.	24,	1934 N	laryland	_
	yland		10a. State 10b. County	10c. Cit	y. Town or Lo	cation						10d. Inside City Limits	
	Mar a-fsi	ctor	Maryland Baltimor	e	Dundal	k						1 ☐ Yes 2 🔯 No	
	or 28	Director	10e. Street and Number			10f. 2	Zip Code			10g. Citi	zen of What C	ountry?	
	23a		3437 Loganview Dri				1222				ted Sta		_
	tems tems	Funeral	11. Marital States	Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Dec If Yes, sp	cedent of Hisp secify Cuban,	anic Origin? (Si Mexican, Puerti	pecify Yes or No o Rican, etc.)		 Race - Am Black, Whi 		
36	rs afti	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 1 No If Yes, Give Year or Dates:		1 🗆 Yes	2√2 No	Specity:		į	Specify: W	Mite	
21215-0036	hin 72 hours after death with the Maryland e. an "naturel", or Hems 23a or 28a-f show Medical Examiner must be nutified at	pa	15. Decedent's Educ	ation	16a. Dece	dent's U	sual Occupation	on .	Y	16b. Ki	nd of Business	/industry	
215	within 72 ene. than "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of t DO NOT	work done dur use retired)	ing most of wor	king				
21	W C T	E O	12 years		Pip	e Fi	tter,				Steel I	ndustry	
B	be filed ital Hygi od other event, I	Be (17. Father's Name (First, Middle, Last)				18	3. Mother's Nan	ne (First, Middle,	Maiden	Sumame)		
<u>yla</u>		၉	Ernest Selby						Humber				_
Maryland	~ ~ ~ =		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Maili	ng Addre	ss (Street and	d Number or Hu	ral Route Numb	er, City o	r Town, State,	Zip Code)	
	1 and 2 Health tem 27		Bessie Selby (Wife)	3437	Loc esition (A	anview	Drive	Dunda.	20c to	Carylar	1 21222 Town, State	-
آور	00-		1 S Burial 2 ☐ Cremation 3 ☐ Re	moval from State			lame of r other place)	. 08/	03/2005				_
Baltimore,			* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License				e Ceme	tery		Frie	endsvil	le, Maryland	d
Ba	permit. Departr Importe eny inju		Vist a Com		D	uda-	Ruck F	uneral	Home of Dundalk	Dune	dalk, I	nc.	
			233 Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the deat							Утапо	Approximate Interval Between	
	Physician		Immediate Cause (Final	1 1000								Onset and Death	
	/Medical		disease or condition resulting in death)	Due to (or as a conseq	uence of):	Ha	LON					+ 0~/	-
10	Examiner		Sequentially list conditions	C. DIFF	ICILE		NEC	TIEN				1 WOEK	
7	שַּׁי פּ	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of							4	
	ecute and -trans	Examiner	that initiated events c.	Due to (or as a conseq	TC	U5	Ē					1 MONTH	
60,	tificate be executed ig physicien and as the burial-transit			255 (5 (6) 45 4 56) (50)	301.00 01).								
68760,	ifficate g phys as the	edical	d.										_
	eath certifi attending for use as	-	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregna		-					23d. Date of de	elivery	
Box	death a atte	Physiclan/N	in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 Feta 4 Pregnant at time of d			pregnancy (specify)				Month	Day Year	
0	that the de led by the a detached	hys	9 Unknown	9L] Unknown									
S, P	The law requires that the death cer tie has been signed by the attendir page 2 should be detached for use	ру Р	Part II. Dther significant conditions conf	ributing to death but not res	ulting in the u	ınderlyin	g cause given	in Part I.	*			to the cause of death?	
Records,	w require been signal								1 🗆	Yes 2	X No 3□P	robably 4 Unknown	_
ecc	e law r has be je 2 sh	Completed							24a. Was auto	psy	24b. Were a prior to	utopsy findings available completion of cause of	
= H		Con							1 ☐ Yes	2 No	death? 1 ☐ Ye	s 2 No	
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:			0.1		th (Check only				_
of	this al di	2	1 Yes 2 0	1 Anpatient 2L	ER/Outpaties 28b. Time of		DOA 28c. Injury a	4 Nursing h	ome 5 Resi			ecify)	
	ding After fune	tlon	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yeer)	Injury	M	Work?	s 2□No	Edd. Describe	11014 111701	y occurred		
Division	l or Attending after death. Director: Afte in by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, st							Rural Route Number,	_
D.	after i Dire	Certification:	4 Hamicide	building, etc. (Special	(y)				City or To	wn, State)		
	pspite hours ineral y filler			ician: To the best of my kno									_
	To the Hospitel or Att within 24 hours after of To the Funeral Direct completely filled in by	edical	(Check only 2 Madical Examin	er: On the basis of examina and manner stated.	ation and/or in				rred at the time,			``	
	To t To t	Σ	29b. Signature and title of certifier			1	29c. License n	number		29d. Da	e signed (Mon	th, Dey, Year)	
			M	X MD				000		30		8, 2005	_
	6		30. Name and address of person who co		n 23a) (Туре, экп Для	Print) (Johns H	opkins	Bayview Marvland	Med 21	ical Ct .224	r.	
	5		Dr. Debashish Bol 31. Date filed (Month, Day, Year)	32. Renistrar's Signa	ature								-
2	St	ate	ALC 0 1 20	All	K 1	break	60						

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
Amend items 7,8 per inf 8851 1-18-06 vt
State of Maryland / Department of Health and Mental Hygiene

1- State Unpend Item 23a&27 per me G846 8-8-05 tas
Registrar

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- State Unpend Item 23a&27 per me G846 8-8-05 tas

Registrar Benjamin Stephenson 05-05095 NJM 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 28 July **Physician** 2005 1617 Wade Benjamin Stephenson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Franklin Square Hospital Rosedale Baltimore 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Months Days Hours 10XM 2□F - 57 Yrs. Director 24, 1927 West Virginia 233-76-4433 Usual Residence of Decedent Maryland 10c, City, Town or Location 10a, State 10b. County 10d. Inside City Limits or than "netural", or Iteme 23a or 28e-f show the Medical Examiner must be notified at 1 XYes 2 No Directo Maryland Baltimore the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 15 Cardinal Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ Specify: White 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Miner Union Carbide 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) s 1 and 2 should be fit I Health and Mental Hitem 27 Is marked ot Benjamin Hubert Donna Myrtle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Donna Elswick P.O. Box 224 Dixie, WV 25059 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 20 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or once. Clay Memorial Gardens 8/1/05 Clay, WV 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wilson Funeral Home 154 Main St., Clay, WV 25043 Mnon ennis 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hypertensive Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine physician and the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Se esn ding 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery atten for u 2 Fetal death 3 Ectopic pregnancy Day Month 4☐Pregnant at time of death 5 Other (specify) signed by the a o 9 Unknown ٦ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Tes 2 No 3 Probably 4 Dunknown been si 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No 24a. Was an page 2 s autopsy performed? certificate 1 Yes 2 No Division of Vital To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 MEP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1

Yes 2 □ No this ctor: After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide within 24 hours after de To the Funerel Directo completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July, 29, 2005 OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

Pamela E. Southall

31. Date filed (Month, Day, Year)

mo

32. Registrar's Signature

		ŕ	1 - For State of Mary	•	artment of Health and rtificate of Death	-	giene Reg. 2 .005	25476
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Dea Month	ath Day Year	3. Time of Death
	/Medic		Mary Edna Smith			July 2	3 2005	6;00 p ^M
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of D	eath	4c. County of Death	
	Francis		15 D Marc Court 5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	Annapolis If Under 1 Year If Under 24 H	Hrs. 8. Date of Birt	Anne Aru	pplace (State or Foreign
	Funeral Director		217-56-3962 ^{1□M 2₺} F 59		Months Days Hours N	Min. (Month, Day Dec. 2	3 1945 Mar	yland
	pu ,		Usual Residence of Decedent 10a. State 10b. County 10	c. City, Town or Lo				101 1-11 01-11-1
	shov	5		-				10d. Inside City Limits 1 Yes 2 □ No
	the N	ect	Maryland Anne Arundel A	Annapoli	10f. Zip Code		10g. Citizen of What Cou	
	3a or	Ö	15 D Marc Court		21403		USA	
	death	Funerai Director	11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Po	(Specify Yes or No-		
98	after or Ite	Fu	1 Never Married 2 Married 1 Yes 2 No		1 ☐ Yes 2 No Specify:	Jeno Alcan, etc.)		, etc. Lack
003	hours urel',	d by	3 ☐ Widowed 4 ₺ Divorced Year or Dates:					
21215-0036	within 72 hours after death with the Maryland ene. Than "neturel" or Items 23a or 28a-f show Ite Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give	dent's Usual Occupation kind of work done during most of DO NOT use retired)	working	16b. Kind of Business/I	ndustry
212	with jene.	mo	Elementary/Secondary (0-12) College (1-4or 5+) 8th		Cook		Restaura	int
	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Ite M.	BeC	17. Father's Name (First, Middle, Last)			Name (First, Middle,		
ylaı	should b ind Menta i marked umatic e	To E	James Griffin		1	Helen Wo	od	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene 1 Health 27 is marked other than "neturel", or Items 23a or 28a-1 show other traumatic event, Ite Medical Examiner must be notified at	d	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or			ŕ
	1 and 2 Heelth tem 27 other tra	1 3	Catherine Parker (Sister) 20a. Method of Disposition	0b. Place of Dispo	Edelmar Dr. A	Annapoli:	s, Md. 214 20c. Location - City or T	
Baltimore,			Paurial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crer	natory or other place)		Drury, Md.	
臣	当年五年		` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee		2. Name and Address of Facility	/23/03	brary, na	
Ba	lmp one		Jam H. Reese Mos	187 V	Vm. Reese & So	ons Mort	uary, P.A.	101
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.		321 West St. in the mode of dying, such as care	Annapolla diac or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ovasa	ular Disess	٥		Onset and Death
	/Medical		resulting in death) Due to (or as a co		0(0)			
П	Examiner	- I	Sequentiary list conditions.	Lenjion	^			1.7-7.9
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	nsequence on:	11.44			1974
Ž	be executed sicien and burial-transit	Exar	that initiated events resulting in death) Last c. Due to (or as a co	nsequence of):	()///			
8760,	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dicai	d					
89	ntifical ng phy as th	(a) †	IF FEMALE:					
Вох	eath certific attending p for use as I	Physician/M	23b. Was decedent pregnant 1 Live birth 2	Fetal death 3	Ectopic pregnancy		23d. Date of delive	ery Day Year
0.	at the dea by the a tached fo	ysici	1 ☐ Yes 2 ₩ 0 4 ☐ Pregnant at time 9 ☐ Unknown 9 ☐ Unknown	of death 5	Other (specify)		Month	Day Toal
P.0	that the		Part II. Other significant conditions contributing to death but no	ot resulting in the ur	nderlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
Vital Records,	uires n sign	d by	Hyper choles twolen.	14		1 🗆 Y	es 2/259No 3 Pro	bably 4 Unknown
00	law require as been si 2 should b	iete) (24a. Was a		opsy findings available
Re	The la ate has page 2	Completed				— autop perfor 1 ☐ Yes	sy prior to co	ompletion of cause of
		BeC	25. Was case referred to medical examiner?		26. Place of I	Death (Check only or		20110
of V	d is	10	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient	2 ER/Outpatien	A Commercial Commercia	g Home 5 🔀 esid	ence 6 Other (Speci	fy)
		ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Ye	ar) 28b. Time of Injury	Work?	28d. Describe h	ow injury occurred	
isio	tence leath tor:	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury -	At home farm etc	M 1 Yes 2 No	28f Location (S	treet and Number or Rur	n/ Pouta Number
Division	7 7 7 6	Certification;	4 Homicide determined 286. Place of injury building, etc. (S	pecify)	eet, factory, office	City or Tow	n, State)	ii noute ivamber,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier 1 Certifying Physician: To the best of m	y knowledge, death	n occurred at the time, date and pla	ace, and due to the o	ause(s) and manner as	stated.
	the Hin 24 the Figure 1919	ledicai	one) and manner stated.	mination and/or inv				
	To To	Σ	29b. Signature and title of certifier	1	29c. License number		9d. Date signed (Month,	_
•			lugue Thomas / la	sion 19.	0 000364		August,1,	2003
	3		30. Name and address of person who completed cause of death Fugere Thirds Plane	200	900 Bestsche	RJ# 307	Annapa	1.5 MD
	• Sta	te	31. Date filed (Month, Day, Year). 32. Polistrar's S	Signature			1	20761
	Registr	ar	AUG 0 4 2005	. K. A	South 1			

			State of Marylan 1- State Registrar	nd / Department of Health and Me Certificate of Death	ental Hygiene 2005	25477
•	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) William P. Scarborough 4a. Facility Name (If not institution, give street and number) LOLION D KWERS, de	4b. City, Town, or Location of Death Boldam o	2. Date of Death Month Day Year July 23 2005 4c. County of Death	3. Time of Death 1:45 PM
<u></u>	Funeral Director	ctor	5. Social Security Number 217-24-1312 Usual Residence of Decedent 10a. State 10b. County 10c. Cit 10 Harford 10 Harford 10 Harford	Months Days Hours Min.	June 14, 1928 MD	olace (State or Foreign ntry) 10d. Inside City Limits 1 □ Yes 2√2 No
30 Rough	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "natural", or Items 23a or 28a-1 show any injury or other treumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	10e. Street and Number 1123 Belcamp Garth 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ▼ Divorced 10e. Street and Number 12. Was Decedent Ever in U. Armed Forces? 1 ▼ Yes. 3 □ No If Yes. Give Year or Dates:	10f. Zip Code 21017 S. 13. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Ri		can Indian,
S CAR BO 1 and 21215-0036	be filed within 72 ho ntal Hygiene. sd other than "natur event, the Medical	Be	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk 17. Father's Name (First, Middle, Last)	dik	(First, Middle, Maiden Sumame)	dustry unk
Baltimore, Maryla	ages 1 and 2 should ent of Health and Mer it: If Item 27 Is marke y or other treumatic	10	19a. Informant's Name/Relationship (Type, Print) Lorien @ Riverside 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 ☑ Other (Specify) in state	Je 19b. Mailing Address (Street and Number or Rural 1123 Belcamp Garth Belc Place of Disposition (Name of semetary, crematory or other place)	camp, MD 21017	
(U) Baltin	permit. F Departme Importer any injur		21. Sign tur Funeral S ruice Licensee 23a. Part Lenter the disease, or complications that caused the death shock, a heart failure. List only one cause on each line.	Baltimore, MD 21201		Street Approximate Interval Between
8760,	Physician /Medical Examiner the private and the private the private the private the private that the private thas the private that the private that the private that the private	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, li any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the condition of the condit	white lung concernation of concernation of concernation of concernation of the concern		Onset and Death
P.O. Box 68	requires that the death certificate is some signed by the attending physically bould be detached for use as the thould be detached for use as the termination.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnant 1 Live birth 2 Fetal 4 Pregnant at time of do 9 Unknown	Il death 3 □Ectopic pregnancy	23d. Date of delive Month	əry Day Year
		Completed by P	Part II. Dther significant conditions contributing to death but not rest	ulting in the underlying cause given in Part I.	24a. Was an 24b. Were auto	ne cause of death? pably 4 Unknown psy findings available mpletion of cause of
Division of Vital Records,	ing Physician: The It. After this certificate h funeral director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No		performed? death? 1 Yes No 1 Yes	2 No
Divis	Hospital or 4 hours afte Funarel Dir tely filled in I	Medical Certification;	4 ☐ Homicide building, etc. (Specify 29a. Certifier Certifying Physician: To the bast of my knot	ome, farm, street, factory, office 28 28 28 28 28 28 28 28 28 2	Coation (Street and Number or Rura City or Town, State) d due to the cause(s) and manner as stated the time, date and place, and due to the cause (s).	tated
•	To the within 2 To the complete	Mec	29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item	29c. License number D 27 975	29d. Date signed (Month, 7/2 7/05	
ı	Sta Registr		31. Date filed (Month, Day, Year) 62. Registrar's Signal AUG 0 4 2005	(I Mac Phail Ad	And Ain Mn	21014

			4	partment of Health and Mental Hygiene entificate of Death	5478								
	Physici /Medio		1. Decedent's Neme (First, Middle, Last) David P. Tice	August 1 2005 5:4	me of Death 45 P. M								
1	Examir	er	4a. Fecility Name (If not institution, give street and number) 317 Coolbreeze Court 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	4b. City, Town, or Location of Death Pasadena Anne Arundel If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9 Birthplace (S)									
ŀ	Funeral Director		153 30 0598 100 M 2 F 70 Yrs.	Months Days Hours Min. B. Date of Birth (Month, Day, Year) June 12, 1935 Hours Min. June 12, 1935 Hours Min. June 12, 1935 Hours Min. June 12, 1935 Hours June 12, 193	rsey								
	e Maryland e-f show iified et	ctor	Maryland Anne Arundel Pasad		ide City Limits] Yes 2 😿 No								
	ath with the 23a or 28	Funeral Director	10e. Street and Number 317 Coolbreeze Court	10f. Zip Code 10g. Citizen of What Country? U.S.									
9036	nit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland satment of Health and Menial Hygiene. cortant: if item 27 is marked other then "naturel", or items 23a or 28a-f show injury or other traumatic event, it is Medical Examinat must be recified at its injury or other traumatic event, it is Medical Examinat must be recified at its.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☑ No Specify: Specify: White	an,								
21215-0036	d within 72 h giene. er then "natu It e Medical	Completed	(Specify only highest grade completed) (Gin	edent's Usual Occupation of kind of work done during most of working DO NOT use retired) scal Clerk 16b. Kind of Business/Industry Department of Safety & Corre	ection								
Maryland	should be filed within nd Mental Hygiene. I marked other then umatic event, II a M	To Be C	17. Father's Name (First, Middle, Last) Dr. Linwood F. Tice	18. Mother's Name (First, Middle, Maiden Sumame) Marjorie Purnell									
	and 2 sho alth and 127 is mu er traume				1122								
Baltimore,	permit. Pages 1 and 2 Department of Health a Important; if item 27 is ony injury or other tra		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery, ci	Crematory 8/3/2005 Baltimore, Mary	·land								
Balt	permit. Departimports eny inji		19a. Informant's Name/Relationship (Type, Print) Wanda Tice / wife 317 Coolbreeze Court Pasadena, Maryland 2. Oa. Method of Disposition 1 Burial 2 Cormation 3 Bernoval from State 20b. Place of Disposition (Name of cemetery, crematory or other place)										
1760, 8	Physician /Medical Examiner per prival transit	cal Examiner	shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, I say, washing to ammodiate cause. Enter Underlying Cause (Disease or injury that infittated events resulting in death) Last Due to (or as a consequence of):		al Between and Death								
.O. Box 68	death certitica e attending ph d for use as th	by Physician/Medic		□Ectopic pregnancy 23d. Date of delivery □ Other (specify) Month Day	Year								
rds, P	quires that the signed by to all doe detach		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did tobacco use contribute to the cause									
Il Records,	hysician: The law requires that the his certificate has been signed by th I director, page 2 should be detache	Completed		24a. Was an autopsy find prior to completion death? 1 \(\text{Yes} \) 2 \(\text{Disc} \) 0 1 \(\text{Yes} \) 2 \(\text{Disc} \) No	of cause of								
of Vital	Physician: this centicanal director, I	To Be	25. Was case referred to medical examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpati	26. Place of Death (Check only one) ont 3 DOA Other: 4 Nursing Home 5 Desidence 6 Other (Specify)									
Division o	or Attending atter death. Director: After in by the fune	Certification:	27. Manner of Death 1	Work? M 1 ☐ Yes 2 ☐ No	Number,								
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely tilled in by the	Medical C	(Check only 2 Medical Examiner: On the basis of examination and/or	th occurred at the time, date and place, and due to the cause(s) and manner as stated. nvestigation, in my opinion, death occurred at the time, date and place, and due to the cau	ıse(s)								
	To the comp	M	29b. Signature and title of certifier And Andrew A	29c. License number 29d. Date signed (Month, Dey, Yes 39505 August 2,	2005								
	Sta	_	30. Name and address of person who completed cause of death (Item 23a) (Type Yudhi Sh Markon 30 5 31. Date filed (Worth, Pay, Year) 5 32. Registrar's Signature	29c. License number 29d. Date signed (Month, Dey, Yei D39505 August 2, Hospital W. Glen Burnie, MD 21	061								
	Registr	ar	Incomes 12 18										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 26 per doc 2846 8-4-05 vt

		•	For State Registrar	Otato	or ivial ylarid		46 8-4-0 artment of l rtificate of				Reg. No. 2 A	05 0-
			Decedent's Name (First, Middle	e, Last)						2. Date of Dea Month	ath CU	3. Time of bleath 9
	Physicia /Medic		Louisa Mary V	icari						July	Day 28, 200	Yeer 5:12 a. M
	Examin		4a. Facility Name (If not institution	n, give street and nu	umber)		4b. City, Town, o	or Location of	of Death	_	4c. County o	f Death
			7617 Chesapeal		1		Edgeme		04 Usa		Balti	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birt (Month, Day		Birthplace (State or Foreign Country)
	Director		212-40-3071 Usual Residence of Decedent		91				L	Feb.	9, 1914	Maryland
	yland		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	Mar-fet	ż	Maryland Bal	timore	E	dgeme	re					1 ☐ Yes 2 ☑ No
	th the	Directo	10e. Street and Number				10f. Zip Code				10g. Citizen of W	hat Country?
	23a	rai	3018 Willow Ave				2121				United :	
	er de (Funerai	11. Marital Status	Armed F		3. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Ori an, Mexi c ar	igin? (Spe n, Puerto F	cify Yes or No- Rican, etc.)	14. Race Black	- American Indian, c, White, etc.
36	rs aft	by F	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, G	2X No live Dates:		1 ☐ Yes 2 № No	Specify:			Specify:	White
2-0036	ba filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or Items 23e or 28e-f ehow event, the Madical Exacilier most be notified at		15. Deceder	nt's Education	1		dent's Usual Occu				16b. Kind of Bus	siness/Industry
215	hin 7.	ple	(Specify only higher Elementary/Secondary (0-12)	st grade completed	(1-4or 5+)	life.	kind of work done DO NOT use retire	auring mos ed)	it of workin	rg		
2121	filed will Hygien sther th ent, the	Completed	10 years			S	eamstres					thing
<u>n</u>	ba fit tal Hi d oth	Be	17. Father's Name (First, Middle,								Maiden Sumame	9)
Maryland	should be filed withing and Mental Hygiene. marked other than umatic event, ITE M.	P_	Guisippi Salamo			10b Mailie	ng Address (Street			laimo	or City or Town S	State Zin Code)
Ma	12 ha				. \		00.51				•	
	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		Louis J. Vicari 20a Method of Disposition	., UL . (SOI	20b. Pla	ace of Dispo	Chesare			ate Edgel		ryland 21219 City or Town, State
ē	ages ant of nt: If i		1 ☐Burial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (5		n State		matory`or other pla Redeeme:		. 8/1	/2005	Baltim	ore, Maryland
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.		21. Signature of Funeral Service		00	22	2. Name and Addre	ess of Facili	ty	_		
m	Per in Se		ya.	- (a	u Q	D 7	uda-Ruck 922 Wise	Funer	ral H ie D	ome of undalk	Dundalk Marvla	, Inc. nd 21222
	100	(23a. Part1 Enter the disease, o	r complications that t only one cause on	caused the death.	. Do not ent	ter the mode of dyi	ng, such as	cardiac or	r respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	7.00.0	Can	note	we 1	tear	t 7	aren	re	Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conseque	ce of):	orons		^		A	
	LXummer	_	Sequentially list conditions, if any, leading to immediate	b								
7	ad isit	9	it any loading to immediate		o (or as a conseque	ence of):	owns	70	est	7 se	serse	
	=	nir.	Cause (Disease or injury		o (or as a conseque	ence of):	own	50	lsli	7 the	serse	
~	execut in and ial-tran	Examir	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	o (or as a conseque	ence of):	own	50	lili	7 11	serse	
. '09/	te ba execut ysician and ie burial-tran	cal Examiner	Cause (Disease or injury that initiated events	C		ence of):	orons	7 ·	lste	7 12	serse	
. (09289	rtificate ba executad ng physician and t as the burial-transit	edicai	cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last	C		ence of):	own	7 ·	esta	J Be	serse	
9	ath certificate ba execut ttending physician and or usa as the burial-tran	edicai	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	c	o (or as a consequent	ence of): ence of): ncy death 3	□Ectopic pregnanc	J	esta	y she		e of delivery th Day Year
Box 6	ne death certificate ba execut the attending physician and hed for usa as the burial-tran	edicai	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	o (or as a consequent of the consequent of pregnan birth 2 Fetal of the consequent at time of dear	ence of): ence of): ncy death 3		J		y 12	23d. Date	
P.O. Box 6	that the death certificate be execut ed by the attending physician and detached for use as the burial-tran	Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	c	utcome of pregnan birth 2 Fetal of pnant at time of dea nown	ence of): ence of): ancy death 3[ath 5[□Ectopic pregnanc □ Other (specify) _	Sy			23d. Date Mon	
P.O. Box 6	uires that the death certificate ba execut is signed by the attending physician and the bedetached for usa as the burial-tra	by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	C. Due to d	utcome of pregnan birth 2 Fetal of pnant at time of dea nown	ence of): ence of): ancy death 3[ath 5[□Ectopic pregnanc □ Other (specify) _	Sy			23d. Date Mon	th Day Year
P.O. Box 6	v requires that the death certific been signed by the attending p should be detached for usa as	by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	C. Due to d	utcome of pregnan birth 2 Fetal of gnant at time of dearnown	ence of): ence of): ancy death 3[ath 5[□Ectopic pregnanc □ Other (specify) _	Sy		23e. Did to	23d. Date Mon	bute to the cause of death? 3 Probably 4 Unknown
P.O. Box 6	e law requires that the death certific has been signed by the attending p je 2 should be detached for usa as	by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	C. Due to d	utcome of pregnan birth 2 Fetal of gnant at time of dearnown	ence of): ence of): ancy death 3[ath 5[□Ectopic pregnanc □ Other (specify) _	Sy		23e. Did to	23d. Date Mon obacco use contri /es 2010 24b. Work pri med?	bute to the cause of death? 3 Probably 4 Unknown 4 Unknown 2 2 3 4 4 4 4 4 4 4 4 4
P.O. Box 6	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	e Completed by Physician/Medical	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions.	Due to c	utcome of pregnan birth 2 Fetal of gnant at time of dearnown	ence of): ence of): ancy death 3[ath 5[□Ectopic pregnanc □ Other (specify) _	ven in Part l	l.	23e. Did to 1 1 24a. Was autop	23d. Date Mon	bute to the cause of death? 3 Probably 4 Unknown Vere autopsy findings available rior to completion of cause of eath? Yes 2 No
Vital Records, P.O. Box 6	ysician: The law requires that the death certific is certificate has been signed by the attending p director, page 2 should be detached for usa as	To Be Completed by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions are in the past 12 months? 1 Yes 2 No 9 No No No No No No No No No No No No No	Due to c	utcome of pregnan birth 2 Fetal cannown death but not result	ence of): ence of): ency death 3[ath 5[Iting in the u	□Ectopic pregnanc □ Other (specify) _ inderlying cause gi	ven in Part I	e of Death	23a. Did to 1 24a. Was autop perfo 1 Yes (Check only one	23d. Date Mon bbacco use contri yes 2200 an 24b. W pl grmed? dence 6 Cothe	bute to the cause of death? 3 Probably 4 Unknown Vere autopsy findings available rior to completion of cause of eath? Yes 2 No
of Vital Records, P.O. Box 6	ysician: The law requires that the death certific is certificate has been signed by the attending p director, page 2 should be detached for usa as	To Be Completed by Physician/Medical	Cause Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions are saminer? 1 Yes 2 No 27. Man or of Death 1 Natural 5 Pendit	Due to c	utcome of pregnan birth 2 Fetal cannown death but not result	ence of): ence of): ncy death 3[ath 5[□Ectopic pregnanc □ Other (specify) □ inderlying cause gi	26. Place ther: 4 No	e of Death ursing Hon	23a. Did to 1 24a. Was autop perfo 1 Yes (Check only one	23d. Date Mon	bute to the cause of death? 3 Probably 4 Unknown Vere autopsy findings available rior to completion of cause of eath? Yes 2 No
of Vital Records, P.O. Box 6	iing Physician: The law requires that the death certific h. After this certificate has been signed by the attending p funeral director, page 2 should be detached for usa as	To Be Completed by Physician/Medical	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions are in the past 12 months? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Many of Death 1 Natural 5 Pendical examiner of Death 1 Natural 5 Pendical examiner of Death 3 Suicide 6 Could	Due to c	utcome of pregnan birth 2 Fetal control of dean nown death but not result and fetal properties of Inpatient 2 E e of Injury onth, Day Year)	ence of): ence of): ence of): ency death 3[ath 5[Iting in the u ER/Outpatier 28b. Time o Injury	□Ectopic pregnanc □ Other (specify) □ underlying cause gi	26. Place ther: 4 No lary at prk?	e of Death ursing Hon 2	23e. Did to 1 1 24a. Was autor period 1 1 Yes (Check only one	23d. Date Mon obacco use contri yes 2000 an 24b. W properties of the control of t	bute to the cause of death? 3 Probably 4 Unknown Vere autopsy findings available rior to completion of cause of eath? Yes 2 No
of Vital Records, P.O. Box 6	iing Physician: The law requires that the death certific h. After this certificate has been signed by the attending p funeral director, page 2 should be detached for usa as	ertification; To Be Completed by Physician/Medical	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions are in the past 12 months? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Many of Death 1 Natural 5 Pendical examiner of Death 1 Natural 5 Pendical examiner of Death 3 Suicide 6 Could	Due to c	utcome of pregnan birth 2 Fetal conant at time of deanown death but not result from the control of the control	ence of): ence of): ence of): ency death 3 [ath 5 [Iting in the u ER/Outpaties 28b. Time o Injury	□Ectopic pregnanc □ Other (specify) □ underlying cause gi	26. Place ther: 4 No lary at prk?	e of Death ursing Hon 2	23e. Did to 1 1 24a. Was autor period 1 1 Yes (Check only one	23d. Date Mon bbacco use contri Yes 2 No an 24b. W. Syrmed? dence 6 Othe now injury occurre	bute to the cause of death? 3 Probably 4 Unknown Vere autopsy findings available rior to completion of cause of eath? Yes 2 No
Vital Records, P.O. Box 6	iing Physician: The law requires that the death certific h. After this certificate has been signed by the attending p funeral director, page 2 should be detached for usa as	Certification; To Be Completed by Physician/Medical	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to c	utcome of pregnan birth 2 Fetal or gnant at time of dearnown death but not result and the death but not result are of Injury on the Day Year) The best of my known be best of my known as a consequence of Injury and the death but not result are of Injury.	ence of): ence of): ency death 3[ath 5[thing in the unity ath 5[ER/Outpaties 28b. Time of Injury me, farm, stop wiedge, deat	DEctopic pregnance Other (specify) Inderlying cause grant 3 DOA of 28c. Injury Market, factory, office	26. Place ther: 4 Note to the Part 1 Note to the Part 2 In	e of Death ursing Hon 2	23e. Did to 1 24a. Was autop perfo 1 Ves (Check only one 128d. Describe Inc. 28f. Location (S. City or Tow	23d. Date Mon obacco use contributes 2 10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	bute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available from to completion of cause of eath? If (Specify estimates and or or Rural Route Number,
of Vital Records, P.O. Box 6	iing Physician: The law requires that the death certific h. After this certificate has been signed by the attending p funeral director, page 2 should be detached for usa as	Certification; To Be Completed by Physician/Medical	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to c. Due to d	utcome of pregnan birth 2 Fetal or gnant at time of dearnown death but not result and the death but not result are of Injury on the Day Year) The best of my known be best of my known as a consequence of Injury and the death but not result are of Injury.	ence of): ence of): ency death 3[ath 5[thing in the unity ath 5[ER/Outpaties 28b. Time of Injury me, farm, stop wiedge, deat	DEctopic pregnance Other (specify) Inderlying cause grant 3 DOA of 28c. Injury Market, factory, office	26. Place ther: 4 Note to the Part 1 Note to the Part 2 In	e of Death ursing Hon 2	23e. Did to 1 24a. Was autop perfo 1 Ves (Check only one 128d. Describe Inc. 28f. Location (S. City or Tow	23d. Date Mon obacco use contributes 2 10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	bute to the cause of death? 3 Probably 4 Unknown Vere autopsy findings available for to completion of cause of eath? Yes 2 No or (Specify) estrence
of Vital Records, P.O. Box 6	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	ertification; To Be Completed by Physician/Medical	Cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to c. Due to d	utcome of pregnan birth 2 Fetal contact at time of deanown death but not result a of Injury onth, Day Year) The best of my know basis of examination of pregnant at time of deanown death but not result a contact and the present the pr	ence of): ence of): ency death 3 [ath 5 [Iting in the u ER/Outpatier 28b. Time o Injury me, farm, str) vledge, deat	DEctopic pregnanc Other (specify) Inderlying cause given the second of t	26. Place ther: 4 New Yes 2 Imme, date ar opinion, deales anumber	e of Death ursing Hon 2 No 2 No and place, a	23e. Did to 1 24a. Was autor perfo 1 Yes (Check only one 128d. Describe In City or Towns and due to the end at the time,	23d. Date Mon bbacco use contri yes 2 10 an 24b. W pr grad 2 11 syred 3 dence 6 10 chenow injury occurre Street and Number wn, State) cause(s) and mar date and place, a 29d. Date signed	bute to the cause of death? 3 Probably 4 Unknown Vere autopsy findings available for to completion of cause of eath? Yes 2 No or (Specify) estrence and or or Rural Route Number, oner as stated. Ind due to the cause(s) (Month, Day, Year)
of Vital Records, P.O. Box 6	iing Physician: The law requires that the death certific h. After this certificate has been signed by the attending p funeral director, page 2 should be detached for usa as	edical Certification; To Be Completed by Physician/Medical	Cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to c. Due to d	utcome of pregnan birth 2 Fetal contact at time of deanown death but not result a of Injury onth, Day Year) The best of my know basis of examination of pregnant at time of deanown death but not result a contact and the present the pr	ence of): ence of): ency death 3 [ath 5 [Iting in the u ER/Outpatier 28b. Time o Injury me, farm, str) vledge, deat	DEctopic pregnanc Other (specify) Inderlying cause given the second of t	26. Place ther: 4 New Yes 2 Imme, date ar opinion, deales anumber	e of Death ursing Hon 2 No 2 No and place, a	23e. Did to 1 24a. Was autor perfo 1 Yes (Check only one 128d. Describe In City or Towns and due to the end at the time,	23d. Date Mon bbacco use contri yes 2 10 an 24b. W pr grad 2 11 syred 3 dence 6 10 chenow injury occurre Street and Number wn, State) cause(s) and mar date and place, a 29d. Date signed	bute to the cause of death? 3 Probably 4 Unknown Vere autopsy findings available for to completion of cause of eath? Yes 2 No or (Specify) estrence and or or Rural Route Number, oner as stated. Ind due to the cause(s) (Month, Day, Year)
of Vital Records, P.O. Box 6	iing Physician: The law requires that the death certific h. After this certificate has been signed by the attending p funeral director, page 2 should be detached for usa as	edical Certification; To Be Completed by Physician/Medical	Cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to c. Due to d	utcome of pregnan birth 2 Fetal of grant at time of deanown death but not result the property of the property	ence of): ence of): ency death 3 [ath 5 [Iting in the u ER/Outpatier 28b. Time o Injury me, farm, str) vledge, deat	DEctopic pregnanc Other (specify) Inderlying cause given the second of t	26. Place ther: 4 New Yes 2 Imme, date ar opinion, deales anumber	e of Death ursing Hon 2 No 2 No and place, a	23e. Did to 1 24a. Was autor perfo 1 Yes (Check only one 128d. Describe In City or Towns and due to the end at the time,	23d. Date Mon bbacco use contri yes 2 10 an 24b. W pr grad 2 11 syred 3 dence 6 10 chenow injury occurre Street and Number wn, State) cause(s) and mar date and place, a 29d. Date signed	bute to the cause of death? 3 Probably 4 Unknown Vere autopsy findings available for to completion of cause of eath? Yes 2 No or (Specify) estrence and or or Rural Route Number, oner as stated. Ind due to the cause(s) (Month, Day, Year)
of Vital Records, P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical Certification; To Be Completed by Physician/Medical	cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to c. Due to d	utcome of pregnan birth 2 Fetal of grant at time of deanown death but not result the property of the property	ence of): ence of): ence of): ency death 3[ath 5[thing in the unit of th	DEctopic pregnanc Other (specify) Inderlying cause grant of 28c. Injunct M 1 reet, factory, office th occurred at the topestigation, in my 29c. Licen	26. Place ther: 4 New Yes 2 Imme, date ar opinion, deales anumber	e of Death ursing Hon 2 No 2 No and place, a	23e. Did to 1 24a. Was autor perfo 1 Yes (Check only one 128d. Describe In City or Towns and due to the end at the time,	23d. Date Mon bbacco use contri yes 2 10 an 24b. W pr grad 2 11 syred 3 dence 6 10 chenow injury occurre Street and Number wn, State) cause(s) and mar date and place, a 29d. Date signed	bute to the cause of death? 3 Probably 4 Unknown Vere autopsy findings available for to completion of cause of eath? Yes 2 No or (Specify) estrence and or or Rural Route Number, oner as stated. Ind due to the cause(s) (Month, Day, Year)

			For State Registrar	State of Marylar		artment o		d Mental Hy	giene	25480
	Physici	an	1. Decedent's Name (First, Middle, Last	Rosetta	Clark	Water	s	2. Date of De Month	30 ^{Day} 2005 ^{Yee}	3. Time of Death 10:38 p.M
	/Medic Examin		4a. Fecility Name (If not institution, give	street and number)			m, or Location of D	eath	4c. County of De	
	LAGITIII	CI	Manor Care Ruxto	n		Tows	on		Balto	
	Funeral		Social Security Number 6. Se	7. Age (In yrs.	- "	If Under 1 Ye	ear If Under 24	Hrs. 8. Date of Bir Min. (Month, Da		inhplace (State or Foreign Country)
	Director		215-14-4351 Usual Residence of Decedent	84	Yrs.	~		10-25		Md
	land ow		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
	Mary Ingl	to	Md	N/A	Balt	0				1 X Yes 2 □ No
	ours after death with the Maryland rel', or Items 23s or 28s-f show Examiner must be notified at	Funeral Director	10e. Street and Number			10f. Zip Cod	de		10g. Citizen of What	Country?
	23a	ral	4803 Tamarind Ro	ad Apt 416			21209		USA	
	er dez	nue	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of Yes, specify (of Hispanic Origin Cuban, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	14. Race - Ar Black, Wi	nerican Indian, nite, etc.
36	hours after turel', or Ite	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 ☒No If Yes, Give Year or Dates:		1□Yes 2∏	No Specify:		Specify:	31ack
21215-0036	s 1 and 2 should be filed within 72 hours if Health and Mental Hygiene. Item 27 Is marked other than "naturel", other treumatic event, the Medical Exe	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual Oc	cupation	addaa	16b. Kind of Busines	ss/Industry
215	within 7 ene. than "n	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life.		one during most of ntired)	working	Social Sec	curity
	led wi ygien yer th	Con	12th grade	2 years		Clerk	40.14.11	hii 200 - 1412 H		ation
and	ntal H ed otl	Be	17. Father's Name (First, Middle, Last) John T. Clark					Name (First, Middle	·	
Maryland	thould mark matic	ဥ	19a. Informant's Name/Relationship (T	rpe. Print)	19b. Maili	na Address (Str		otte Clay	Y CON er, City or Town, State	Zin Codel
Ma	Ith an 12 s 15 ls lth an 17 ls ls ls ls ls ls ls ls ls ls ls ls ls		Valerie Craig - Da			•)2 Balto, N	
Baltimore,	permit. Pages 1 and Department of Heali Important: If Item 2 any injury or other ance.		20a. Method of Disposition		Place of Dispo	sition (Name or matory or other	t I	Date	20c. Location - City	
E	Page nent c int: If		1 Purial 2 □ Cremation 3 □ F 1 Other (Specify)	removal from State	-	-	1 Park 8-	-4-2005	Arbutus,	Md
alti	permit. Departm Importa any inju		21. Signature of Funeral Service Licens				dress of Facility	March F		
<u> </u>	82589		Hrome -	t shumpe				ash Avend		Md 21215
			23a. Pert1. Enter the disease, or comp shock, in heart failure. List only of	ne cause on each line.		1	1	A	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cave (Final disease or condition resulting in death)			elve	1 which	my W.	reuse	years
	Examiner			Due to (or as a consec	quence of):			J		0
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consec	quence of):					
./	outed od ransit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	d						
٧,	certificate be executed rding physician and use as the burial-transit		resulting in death) Last	Due to (or as a consec	quence of):					
8760,	ate b	dicai	•	d						
9 ×	Jeath certifica attending ph I for use as th	w I	IF FEMALE:	23c. If yes, outcome of pregn	ancy				204 D-4	
Вох	atter for u	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3	☐Ectopic pregna ☐ Other (specify			23d. Date of o	Day Year
0	that the de ed by the detached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
ď			Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	nderlying cause	given in Part I.	23e. Did 1	tobacco use contribute	to the cause of death?
Vital Records,	v requires been sign should be	Completed by	Conjestive Ma	n raum t				_ 10	Yes 2 No 3	Probably 4 Unknown
ecc	aw as b	pie	Chrone r	nal jarl	me			_ 24a. Was	an 24b. Were prior to	autopsy findings available ocompletion of cause of
E B	That are page	Соп	mareles Me	Ulus				perfo 1 🗆 Yes	ormed? death	? es 2□No
Vita	Physiclen: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Death (Check only		
	Phys rthis ral di	<u>۲</u>	1 Yes 2 No	1 Inpatient 2	ER/Outpatier 28b. Time o	IL 3 DOA	4 - Nursir		dence 6 Other (Sp.	pecify)
on	Attending I ir death. ector: After by the funer	tion	1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury		Injury at Work? 1 □ Yes 2 □ No		,,	
Division of	Attendi r death. ector: A by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, sti	reet, factory, offi	ice	28f. Location (City or To	Street and Number or	Rural Route Number,
Ö	tel or s afte el Dir ed in	Cert	1/	duilding, etc. (Opecin	·y/			Ony of 10	wii, Giate)	
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director; A completely filled in by the fu	edicai	(Check only 2 Medical Exem	sician: To the best of my kno ner: On the basis of examina	owledge, deat	h occurred at th	e time, date and p	lace, and due to the	cause(s) and manner date and place, and d	as stated.
	the hin 2, the public	Med	one) 29b. Signature and title of certifier	and manner stated.			ense number		29d. Date signed (Mo	
	5 1 × 0	-	290. Signature and time of certified	In (w)		250. 210	20422			2
	/		30. Name and address of person who c	ompleted cal se of death (Iter	m 23a) /Tveo	Print)	00 12 2		100011	2005 4 MOZIZO4
	5		MDHU MO	CASMIL	6201	NC	MARYES	57	SHITIMOR	# MO21204
	Sta Registr	٠	31. Date filed (Month, Day, Year)	32. Registrar's Signature	ature!	freeze				

			For State	State of Ma		artment of Healt		lental Hygi	ene	
			Registrar 1. Decedent's Name (First, Middle, Last)		Ce	ertificate of Dea	ttri	2. Date of Death	g. No. 200	5 25481
	Physicia	an		_	T	rr_ 3 3		Month	Day Year	
	/Medic		4a. Facility Name (If not institution, give s		Lawrence	Woll 4b. City, Town, or Locat	tion of Dooth	July 2	29, 2005 4c. County of De	10:42A ^M
	Examin	er			asl atm		more Ci	+	4c. County of De	N/A
	Funeral		Johns Hopkins Bay 5. Social Security Number 6. Sex		(In yrs. last birthday		nder 24 Hrs.	8. Date of Birth	9. B	irthplace (State or Foreign
	Funeral Director			M 2□F	81 Yrs.	Months Days Hou	urs Min.	(Month, Day, April 1'	rear) (nnsylvania
	9		Usual Residence of Decedent							
	how	L ,	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	8e-1	Director		imore		Dundal]	k			1 ☐ Yes 2 ☑ No
	vith th	Die	10e. Street and Number			10f. Zip Code		10	g. Citizen of What (·
	s 23e	ra	92 Kinship Road			21222	0:10/5		United	
	it er de	Funeral	11. Marital Status 1 Never Married Married	12. Was Decedent I Armed Forces? 1X Yes 2 □ N		Was Decedent of Hispanie If Yes, specify Cuban, Me	c Origin? (Spe xican, Pueno	Rican, etc.)	Black, Wh	nerican Indian, iite, etc.
36	hours after deeth with the Maryland ture!, or items 23e or 28e-f ehow al Examiner must be notified at	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No Spe	ecify:		Specify:	White
15-0036	2 hou	ed	15. Decedent's Educ	cation	16a. Dece	edent's Usual Occupation		1	6b. Kind of Busines	
212	filed within 72 Hygiene. kther than "nat ent, the Wedle	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) Cotlege (1-4or 5	life.	e kind of work done during DO NOT use retired)	most of worki	ng		,
2	giene general	E C		6 Years		chool Teacher	r	5	Sparrows :	Pt. High
9	be filed within 72 hours after deeth with the Marylan Hygiene. d other than "naturel", or items 23a or 28e-f show event, the Modical Examinar must be rediffed at	Be (17. Father's Name (First, Middle, Last)			18. M	fother's Name	(First, Middle, M	aiden Sumame)	
<u>a</u>		2	William Woll	To the section			Theres	sa Kremei	<u> </u>	
=	0 = 0		19a. Informant's Name/Relationship (Ty) Mrs. Anne Grace W			ing Address (Street and No Kinship Road		d <i>R</i> oute Number. ∃alk, Mai		<i>Zip Cod</i> e) 2 1 222
ନ୍	s 1 end 7 Health item 27 other tu		20a. Method of Disposition		20b. Place of Disp		0	ate 2	Oc. Location - City of	r Town, State
Baltimore,	Peges nent of int: If it iry or o		1 ∑xBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation, 5 ☐ Other (Specify)	emoval from State		ematory or other place) Ht. of Jesus	Cem. 8	3/2/2005	· Dundalk	. Marvland
=======================================	permit. Peg Department Important: h any injury o		21. Signature Funeral Service License	R /	1 2	2. Name and Address of F	acility			
ñ	8 3 E 8		Espedon C	Ken		Duda-Ruck Fu: 7922 Wise Ave				
			23a. Part1. Enter the disease, or compli- shock, or head failure—List only or	cations that caused						Approximate Interval Between
E. F	Physician		Immediate Cause (Finat disease or condition	Acu	1	naythmia				Onset and Death
<i>f</i>	/Medical		resulting in death)	Due to (or as	a consequence of):	1009	/			7(200355)
	Examiner		Sequentially list conditions,	(ts	(2)					YEAR
/	Sit ad	lne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	а сопъециенсе от):					0
	and and II-tran	Examin	that initiated events resulting in death) Last	Due to (or as	a consequence of):					
8/60	certificata be executed rding physicien and use as the burial-transit	dlcal E								
89	ficate g phy: as the	edic							1	
X R O	eath certific ettending p	2	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome		De			23d. Date of d	elivery
	death	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at		□Ectopic pregnancy □ Other (specify)			Month	Day Year
o,	at the by th tache	hys	9 🗆 Unknown	9Ll Unknown						
Ś	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions con	`			Part I.	23e. Did toba		to the cause of death?
ecord	equir sen s	ted	(サイントを)から	· > \	1,38008			1 Tes	3 □ 1	Probably 4 Unknown
ပ္တ	law desp	Completed						24a. Was an autopsy	24b. Were a	autopsy findings available completion of cause of
	cete hes page 2 :	S						perform 1 ☐ Yes 2	ed? death?	s 2 No
Vital	sician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	ospital:		Othon	Place of Death	Check only one)	
5	his his	2	1 Yes 2 No	1 🗌 Inpatie 28a. Date of Injur	nt 2 ER/Outpatie			me 5 Resider 28d. Describe hov	nce 6 Other (Sp	ecify)
<u> </u>	r Attending Physer death. rector: After this control to the funeral director.	틸	1 Natural 5 Pending 2 Accident investigation	(Month, Da)	Year) Injury	of 28c. Injury at Work? M 1 ☐ Yes		200. Describe 1104	windary occurred	
DIVISION	or Attend after death Director: / d in by the f	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ury - At home, farm, si			28f. Location (Stre	eet and Number or F	Rural Route Number,
	s after si Dire	Certification:	4 Homicide determined	building, etc	: (Specify)			City or Town,	State)	
	To the Hospital of within 24 hours aft To the Funerel D completely filled in	edical	29a. Certifier 1 Certifying Phys	ician: To the best of er: On the basis of and manner sta	examination and/or it	th occurred at the time, dat nvestigation, in my opinion,	e and place, a	and due to the cau ad at the time, dat	use(s) and manner a se and place, and du	as stated. ue to the cause(s)
	Vithin omple	Med	29b. Signature and title of certifier			29c. License numb	ber	29	d. Date signed (Mor	nth, Day, Year)
, '	->-0		ANT Vist	7>		9364	30		8116	
	Q)	1	30. Name and address of person who co	mpleted cause	eath (Item 23a) (Type		-		-1.5	-
-	A P	1	Jeffrey Richardson	M D O	110 D		- 71- 34	Sec I see	21222	
	841		31. Date filed (Month, Day, Year)		LIZ DUNGAL ar's Signature	k Ave. Dund	alk, Ma	aryrand	21222	

4. Facility Internal Front Production of Description of Production of Description of Production of Description of Production of Description of Production of Description of				For State Registrar	State	of Maryla	nd / Depa	artmen rtificate			and M		gien Reg. Ne		05	25	482
## Facility Name of from sensional pass used and numbers 4.09 Browner 1.00 Br				Decedent's Name (First, Middle		nette	Melanie	Wil	son			Month	Da		Year	-	Death A M
Sound State Sound Soun	7			4a. Facility Name (If not institution	n, give street and nu	ım <i>ber)</i>		4b. City,	Town, or	Location o	of Death	2			Death		
Discourse of the property of t				409 Brownell	Road										Ltim	ore Co	
Date Processor of December 10.5 Since 10.5 County 10.5							• • • • • • • • • • • • • • • • • • • •					8. Date of Bir (Month, Da	th y, Year)	9. Birthp Cour	place (State ontry)	r Foreign
10.5 Stees 10.0 County 10.5 City, Town or Location 10.7 Exc Cide 10.7 City City Cide 10.7 City Cide 10.7 City Cide 10.7 City Cide 10.7 City Cide 10.7 City Cide 10.7 City Cide 10.7 City Cide 10.7 City Cide 10.7 City Cide 10.7 City Cide 10.7 City City Cide 10.7 C		Director				62	Yrs.					Jan. 2	8,19	943	Mar	yland	
Type of the second program of the sease, or complications that example the sease of religion to		land III				10c. (City, Town or Lo	cation							1	10d. Inside C	ity Limits
Type of the second program of the sease, or complications that example the sease of religion to		Mary	ţō	Marayal and T	on1+imoro					Midd	ו מוּוּ	River				1 🗌 Yes	2⊠No
Type of the second program of the sease, or complications that example the sease of religion to		r 28a	irec		arcimore.			10f. Zip	Code	TILGO	110 1	. LIVEI	10g. C	itizen of W	nat Cour	ntry?	
Type of the second program of the sease, or complications that example the sease of religion to		th wit	aiD	409 Brownell	Road					212	220		Ţ	Unite	d St	ates	
Type of the second program of the sease, or complications that example the sease of religion to		r dea	Iner	11. Marital Status			U.S. 13.	Was Deced	ent of Hi	spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.))-				
Type of the second program of the sease, or complications that example the sease of religion to	36	s afte	y Fu	•	If Yes, G	ive											
Type of the second program of the sease, or complications that example the sease of religion to	8	turai E E	ed b			Jates:	16a Dece	dent's lileus	I Occupa	ition			16h k	Cind of Rue			
Type of the second program of the sease, or complications that example the sease of religion to	15	n 72	piet	(Specify only highe	st grade completed)		(Give	kind of wor DO NOT us	rk done d e retired,	uring most	of worki	ng					ler
Physician Middical Examiner 23. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dyng, such as cardiac or respiratory arrest. Immediate cause (final resulting in death) Part II of the such as a consequence of it was a conseque	212	the second	E	Elementary/Secondary (0-12)				Secre	tary	,					_		
Physician Middical Examiner 23. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dyng, such as cardiac or respiratory arrest. Immediate cause (final resulting in death) Part II of the such as a consequence of it was a conseque	p	at Hys		17. Father's Name (First, Middle,	Last)					18. Mother	r's Name	(First, Middle,	, Maidei	n Sumame)		
Physician Middical Examiner 23. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dyng, such as cardiac or respiratory arrest. Immediate cause (final resulting in death) Part II of the such as a consequence of it was a conseque	<u>X</u>	Ment	Tol	James W. Pa	au1						Mary	E. Wa	rlic	ck			
Physician Middical Examiner 23. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dyng, such as cardiac or respiratory arrest. Immediate cause (final resulting in death) Part II of the such as a consequence of it was a conseque	Jar.	2 sh 2 and 7 ie m				Juchand											220
Physician Middical Examiner 23. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dyng, such as cardiac or respiratory arrest. Immediate cause (final resulting in death) Part II of the such as a consequence of it was a conseque	_	1 and Health Im 27 Ther t			WIISON (F					Noad							
Physician Middical Examiner 23. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dyng, such as cardiac or respiratory arrest. Immediate cause (final resulting in death) Part II of the such as a consequence of it was a conseque	JO.	ages nt of l		1 ☐ Burial 2 ☐ Cremation		State	cemetery, crer	natory or or	ther place								and
Physician Middical Examiner 23. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dyng, such as cardiac or respiratory arrest. Immediate cause (final resulting in death) Part II of the such as a consequence of it was a conseque		artme ortan injury			man and the same of the same	nenc,	/										.and
Physician Medical Examiner Part College Part Col		Deprimental period		the !!	N. Fr	My											
PRIVISICIAN (ModelCall Examiner) Sequentially list conditions (assasse or condition in essuiting in death) Due to (or as a consequence of): Due to (or as a consequence of): Sequentially list conditions (assasse in conditions) Sequentially list conditions (ass				23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the de each line.	ath. Do not ent	er the mode	e of dying	, such as	cardiac o	r respiratory a	rrest,			Interval Bet	ween
Due to (or as a consequence of): Sequentially lat conditions Due to (or as a consequence of):				disease or condition	_a. \	1 nc	Can	car	hat	- Y	not	rester	22-			Onset and I	Death 3
Souvenistly list conditions Souvenistly list conditions Due to (or as a consequence of): Due to (or as a				resulting in death)	Due to	(or as a cons										0	
Section Part			-	Sequentially list conditions,	b. Due to	for as a conse	equence on.										
Section Part	V:	uted d ansit	E L	cause. Enter Underlying Cause (Disease or injury	S .		,										
FEMALE: 23d. Date of delivery 23d. Date of Death (Check only one) 23d. Date of Death (Check only one) 23d. Date of Death (Check only one) 23d. Date of Death (Check only one) 23d. Date of Death (Check only one) 23d. Date of Death 23d. Dat	o Î	exec an an	Exa		Due to	(or as a conse	equence of):										
FEMALE: 23d. Date of delivery 23d. Date of Death (Check only one) 23d. Date of Death (Check only one) 23d. Date of Death (Check only one) 23d. Date of Death (Check only one) 23d. Date of Death (Check only one) 23d. Date of Death 23d. Dat	876	cate be ohysicie the bu	dical		d												
25. Was case referred to medical examiner? 25	9 ×	ding p	/Me		23c. If yes, ou	itcome of area	nancy										
25. Was case referred to medical examiner? 25	e e	atten atten I for u	cian	in the past 12 months?	1 Live	birth 2 ☐ Fe	tal death 3						- 1			•	Year
25. Was case referred to medical examiner? 25	0	the c by the achec	hysi		9□ Unkn	nown											
25. Was case referred to medical examiner? 25	or i	ned the	y P	Part II. Other significant condition	ons contributing to d	leath but not re	esulting in the ur	nderlying ca	ause give	n in Part I.		23e. Did to	obacco	use contrib	ute to th	ne cause of d	eath?
25. Was case referred to medical examiner? 25	ğ	en sig										101	Yes 2	!□No 3	☐ Prob	ably 4 🗗	Inknown
25. Was case referred to medical examiner? 25	မင်	lawr as be	pie											24b. We	ere auto	psy findings	available
29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tille of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who competed cause of death (Item 23a) (Type, Print) State 31. Date filled (Month, Day, Year) 32. Repstrar's Signature	<u> </u>	cete h	Cou									perfo	rmed?	de	ath?		
29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tille of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who competed cause of death (Item 23a) (Type, Print) State 31. Date filled (Month, Day, Year) 32. Repstrar's Signature	Vita S	certifi ector	Be	examiner?					0		of Death	(Check only o	ne)				
29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tille of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who competed cause of death (Item 23a) (Type, Print) State 31. Date filled (Month, Day, Year) 32. Repstrar's Signature	o	Phys this ral dir			1 1 1				A	4 L Nur						v)	
29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tille of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who competed cause of death (Item 23a) (Type, Print) State 31. Date filled (Month, Day, Year) 32. Repstrar's Signature	٦ 9	ding h. After fune	tion	1 Natural 5 Pendin		nth, Day Year)	Injury					ad. Describe r	iow inju	iry occurred	ı		
29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tille of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who competed cause of death (Item 23a) (Type, Print) State 31. Date filled (Month, Day, Year) 32. Repstrar's Signature	/isi	Atten r deal octor	fica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place	e of Injury - At	home, farm, stre					28f. Location (S	Street ar	nd Number	or Rura	I Route Num	ber.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ā	s effe	Cert	4 Homicide	build	ling, etc. (Spec	cify)					City or Tov	wn, State	θ)			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		Hospit 24 hour Funer stely fills		Check only 2 Medical	Examiner: On the b	pasis of examin	nowledge, death nation and/or inv	occurred a	at the time in my op	e, date and inion, deat	d place, a	and due to the e	cause(s date an	and manr d place, an	ner as st	ated. the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		vithin o the	Me			stated.		29c.	License	number			29d. Da	ate signed (Month, i	Day, Year)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) 32. Registrar's Signature) '	->-0) (So.		4-		1)carl	11000	c						
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature				30. Name and address of person				Print)						- , ([
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		3			wholin S	ynare	Dare	St	: 32	B	Alex	nore	7	(0)	212	33	
Registrar AUG 0 4 2005 Mague & Application		Sta Registr			4 2005	tegistrar's Sign	nature # #	borte	j								

			1 - For State Registrar Amend item 1. Decedent's Name (First, Middle, Las	State of Maryla #5 Per FH G8					d Mental Hy	Reg. No.	005	25183
	Physici /Medi	cal	PATRICIA 4a. Facility Name (If not institution, give	WARD	· · · · · · · · · · · · · · · · · · ·	4h City 1	Town, or Lo	action of D	JULY	Day 25	Year 200	5 11.10 PM
	Examir	ier	1 4 4 1 1 4 4	UCSIS CITY			CSIV (eatn		ounty of Dea	
	Funeral Director		322-10-9492	9x 7. Age (In yi	s. last birthday) Yrs.	If Under Months		Under 24 I	Hrs. 8. Date of Bi lin. (Month, D May 10	irth (ay, Year)	9. Bir Co N	thplace (State or Foreign buntry) ew York
	the Maryland 28a-f show notified at	ctor	Usual Residence of Decedent 10a. State 10b. County MD Howard	10c. (City, Town or Lo		ty					10d. Inside City Limits
	sa or 2	i Dire	10e. Street and Number 3000 North Ridge	Road		10f. Zip		21043		10g. Citize	n of What Co	ountry?
36	within 72 hours after death with the Maryland ane. than "natural", or items 23s or 28s-1 show the Medical Evarriner must be rootified at	by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decede If Yes, speci	ent of Hispa ify Cuban, I		(Specify Yes or Numerto Rican, etc.)		. Race - Ame Black, Whit	
215-00	hin 72 hours a. an "natural" Medical Ex	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation	(Give	dent's Usual kind of worl DO NOT use	k done duri	n ng most of	working unk	16b. Kind	of Business	Industry
Maryland 21215-0036	should be filed withir of Mental Hygiene. marked other than imatic event, the Man	Be	12 17. Father's Name (First, Middle, Last)	4		·	18		Name (First, Middle	, Maiden Su	лтате)	urity Adm
aryla	d 2 should th and Men 7 Is marke treumatic	Ը	Clifford Gunther 19a. Informant's Name/Reletionship (T		19b. Mailir	ng Address	(Street and		ne Chalai			Zin Code)
	1 and 1 and		Darney Ruck/niece 20a. Method of Disposition		9623 Place of Dispo	Spar	row C		Ellicott Date	City,		1042
Baltimore,	it. Page rtment c rtent: If njury or		1 Burial 2 Cremation 3 1 4 Donation 5 Other (Specify, 21. Signature of Funeral Service Licens		cemetery, crer		,	Facility	ard 655 W	7 D-1		G
ä	Dermi Depa Impo any ii		1 de mail	1/1/1000	E	Baltim	ore,	MD 2	1201		timore	Street
	Physician /Medical Examiner	6 11	23a. Part. Enter the disease, or comp shock or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS							_	Approximate Interval Between Onset and Death
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	obstra	0010	~ (me-a	VAR) C	184 1536	<u>-</u>	
68760,	ate be executed hysician and the burial-transit	dical Examin	that initiated events resulting in death) Last	b. CHONIC Due to (or as a conse OBSTRUC Due to (or as a conse SNGST	equence of):	ItE/M	LT F	77 LU	ΛĒ			
P.O. Box 68	requires that the death certifica een signed by the atlending pl nould be detached for use as t	Completed by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pre				23d	. Date of deli Month	very Day Year
	w requires that been signed b should be deta	d by Pl	Part II. Other significent conditions co	ntributing to death but not re	sulting in the ur	nderlying car	use given ir	Part I.				the cause of death?
Division of Vital Records,	aw s b	omplete	HTPOTH	ARTHUTIS						psy pmed?	prior to death?	topsy findings available ompletion of cause of
/ital	cian: ertifica ector, p	Be	25. Was case referred to medical examiner?					Place of D	1 ☐ Yes leath (Check only o		1 🗌 Yes	2 No
of	Physical Company of the serial direction of the serial	2	1 Yes 2 No 27. Manner of Death	lospital: 1 Inpatient 2 [28a. Date of Injury	28b. Time of		c. Injury at Work?	Nursing	Home 5 Resident			rify)
/ision	To the Hospitel or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this cartificate ha completely filled in by the funeral director, page:	Certification:	1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	(Month, Day Year) 28e. Place of Injury - At	Injury	М	1 🗌 Yes	2 🗆 No				ral Route Number,
ρį	spitel or ours after neral Dire		29a. Certifying Phy	building, etc. (Spec	ify)	L Occurred at	t the time of	ate and pla	City or Tox	wn, State)	-	
	the Ho hin 24 h the Fu npletely	Medical	one)	ner: On the basis of examinand manner stated.	ation and/or inv	estigation, in	n my opinio	n, death oc	curred at the time,	date and pla	ice, and due	to the cause(s)
)	Twit		29b. Signature and title of certifier	Privant o		2	License nui			29d. Date si	igned (Month	? Day, Year)
			30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type, F 522	DEL PH	n s	MEE	T, BATT	IMPRE	mo 2	1217
	Sta Registr	te ar	31. Date filedr/Mgnth, Day, Year)	32. Registrar's Sign								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 Month **Physician** 22 10:45 a M William Melroy Widenor July /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3832 Park Lake Drive Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2□ F 202-07-9718 91 Director May 6, 1914 New Jersey Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 ☐ Yes 2 ☐ No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3832 Park Lake Drive 20853 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 □ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer Chemicals 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Melroy Widenor ဂ္ Amelia Strackbein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katrina W. Martin/daughter 3832 Park Lane Drive Rockville, MD 20853 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 Nonetion 5 ☐ Other (Specify) 21. Signature of Funeral Solvice Licensee Rohald S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DEHTARATI WEGICS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): or Attanding Physician: The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached the 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 3 ☐ Probably 4 ☐ Unknown peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performed certificate 1 Yes 2/1/No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 \(\text{Yes} \) 2 \(\text{No} \) 26. Place of Death (Check only one) Certification: To Be Hospital: 1 Inpatient 2 No Other: 3 DOA 4 Nursing Home 2 ER/Outpatient 5 Residence 6 ☐Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month Dev Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID B. HARDINE PRINCE PHILIP DA + 500 OLNEY MO 20832 18/11

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

G 0 4 2005

32/Registrar's Signature

			For State	State of Man		-	nt of Hea te of De		, ,	.00	000	
			Registrar 1. Decedent's Name (First, Middle, Las	st)		Terunca	le oi De	alli	2. Date of Dea	eg. No	LUU 5	25485
	Physici		Betty	Е.			Yer	bv	July	Day 29	200	5 6:25p. M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. Cit		ation of Death			County of De	
			Stella Maris T	owson			Towson	n			Balt	imore
	Funeral		5. Social Security Number 6. S	9x 7. Age (II	n yrs. last birth	Months	r 1 Year If	Under 24 Hrs. lours Min.	8. Date of Birth	Year)		irthplace (State or Foreign Country)
	Director		220-30-6281 Usual Residence of Decedent	[™] ² × 7.	1 Y	S.			08 02	3	3	MĎ
	land ow		10a. State 10b. County	10	c. City, Town	or Location						10d. Inside City Limits
	Man,	tor	MD NA		Balti	more						1 TYes 2 No
	th the	Director	10e. Street and Number		Duru		p Code		1	0g. Citiz	en of What C	Country?
	th wil		740 Poplar Gro	ve St. Api	t 6R		212	16			U.S.	Δ
	tams	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?		13. Was Dec			pecify Yes or No-	1		nerican Indian,
9	hours after death with the Maryland tural', or Itams 23a or 28a-f show Lerarill at must be motilled at	by Fu	1 Never Married 2 Married 3 Vidowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give		1 🗆 Yes		pecify:	,		Snecify:	
ခို	n 72 hours after death with the Marylan "natural", or Itams 23a or 28a-1 show sulc Enarith at the notitied at	ed t	15. Decedent's Ed	Year or Dates:	162 0		ual Occupation					Black
ر 15	be filed within 72 ha tal Hygiene. d other then "natu event, tre Medical	Completed	(Specify only highest gra	de completed)	1 (4	Give kind of wife. DO NOT	ork done durin	g most of work	king	IOD. KIN	d of Busines	s/industry
7	d with	mo:	12th grade	College (1-4or 5+) na		Beaut	ician			9,	alf E	mployed
9	be filed tal Hygi d other event, t	Be (17. Father's Name (First, Middle, Last)					Mother's Nam	e (First, Middle, I	Maiden :	Sumame)	mproyed
yla		To	Joseph Johnson				Ge	eorgeg	ine Mo	lle	У	
Maryland 21215-0036	2 8 8		19a. Informant's Name/Relationship (7						ral Route Number			Zip Code)
	1 and Health Am 27 thar tr		Linda Ingram-D 20a. Method of Disposition		34	24 Ch	ristor		Ct., Ba.			21244
Baltimore,			XXBurial 2 Cremation 3	Homovar Hom State	20b. Place of D cemetery,							r Town, State
			'4 □Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		Garris	on Fo	rest 1	Vet. 8	/4/05	Owi	ngs M	ills, Md
n	permit. Departr Import. any inj		Yal M	221/		March	nd Address of	vest	Baltin		ь ма	21215
			23a Part 1. Enter the disease, or com- shock, or heart failure. List only	dications that caused the	death. Do no	enter the mo	de of dying, su	ich as cardiac	or respiratory arre	est,	e, ma	Approximate
	Physician		Immediate Cause (Final disease or condition	a LUNG CANO	סשי							Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a co		:						
	Examiner	_	Sequentially list conditions,	b								
,	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence of)	:						
1	be executed ician and burial-transit	xan	that initiated events resulting in death) Last	c Due to (or as a co	onsequence of)							
20	icate be executed physician and s the burial-transit	dical E	l		,							
Q	death certificate e attending phys d for use as the	ledic		u								
ŏ	th cer endin	Physiclan/Me	200. Was decedent prognant	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐		3 ☐Ectopic p	170.000 O.V			23	3d. Date of de	elivery
о С	e dea he att	sicla	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time		5 Other (s					Month	Day Year
	d by th	Phy	9 Unknown									
Š,	w requires that the death certific been signed by the attending p should be detached for use as	by	Part II. Other significent conditions co	ontributing to death but no	ot resulting in th	e underlying	cause given in	Part I.				to the cause of death?
cords	v requ been should	ompleted							1016	'S 2L]No 3∏P	robably Tunknown
ā a	sicien: The law s certificate has b lirector, page 2 st	dm							24a. Was au autops perform	y	24b. Were a prior to death?	utopsy findings available completion of cause of
	n: Ti ificate or, pa	မ Co	25. Was case referred to medical						1 ☐ Yes 2	X No	1 ☐ Ye	
5	Physicien: this certific ral director,	0 8	examiner?	Hospital: 1 ☐ Inpatient	2 ER/Outp	atient 3 \(\D			h <i>(Check only on</i> ome 5 ☐ Reside		5 0	
0	g Ph ter thi	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Tim	e of	28c. Injury at Work?	- Nursing Ao	28d. Describe ho	w injury	occurred	HOSPICE
IVISION	endin sath. or: Afr	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation		2// 11/10	M	1 Tes	2 🗆 No				
ž	or Att ter de iract n by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm	, street, factor	y, office		28f. Location (Str City or Town	eet and , State)	Number or A	lural Route Number,
2	urs al		T 0 (1)									
	To the Hospital or Attending Physicien: within 24 hours after dealt within 24 hours after dealt with the funeral Director. After this certific completely filled in by the funeral director,	edical	29a. Certifier (Check only one) (Check only one)	/sician: To the best of my iner: On the basis of exa and manner stated.	y knowledge, o imination and/o	leath occurred or investigation	l at the time, da n, in my opinior	ate and place, n, death occurr	and due to the ca red at the time, da	use(s) a ite and p	ind manner a place, and du	s stated. e to the cause(s)
	o the	Me	29b. Signature and title of certifier	and mariner stated.		29	c. License nun	nber	29	d. Date	signed (Mon	th, Day, Year)
	, , , ,		1				D 437	25			8/11	105
	3		30. Name and address of person who d	ompleted cause of death	(Item 23a) (Ty		_ ' _ '			<u> </u>	3/1/	
	2		DR. TARIQ MAHMOO			LLEY E	D. TI	MONIUM,	MD 2109	3		
		e	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	bosele						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year Morris Zaidband 30, July 2005 11:13 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Silver Spring

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 3701 International Drive Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Months Yrs. Director 131-24-2396 93 July 9, 1912 Poland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Exemple must be notified at Directo 1 ☐ Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ò 3701 International Drive or Items 23a 20906 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 Divorced natural White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed w h and Mental Hygier 7 is marked other th Jeweler Jewelry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should t. Department of Health and Ment. Important: If item 27 is marked Jacob Zaidband <u>Rebecca Kaufman</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Zaidband (Wife) 3701 International Dr., Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Beth Moses Cemetery 8/1/05 Pinelawn, NY 22. Name and Address of Facility
Parkside Memorial Chapel
98-60 Queens Blvd., Forest Hills, NY 21. Signatur of Funeral Service License any ii 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Alzheimers Dementia 3 Years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Tarry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a sonsequence or): The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. physician Physician/Medical as the t IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Į, in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cerebrovascular Insufficiency 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Prostate Cancer 24a. Was an page 2 certificate has autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Aftert Certification; 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signatur and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0035045 July 31, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip G. Henjum, M.D. 3416 Olandwood Ct. #204 Olney, M.D. 20832 31. Date filed (Month, Day, Year) AUG 0 4 2005 . Registrar's Signature State

Registrar

amend item#/, perFH, G846, 8/4/05 TT State of Maryland / Department of Health and Mental Hygiene

1- State of Maryland / Department of Health and Mental Hygiene
1- State of Maryland / Department of Health and Mental Hygiene
1- State of Maryland / Department of Health and Mental Hygiene 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AMMUST 8:00F ZILBERBRAND RAKHIL /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 1933 9. Birthplace (State or Foreign
Country) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕱 F 05/10/1982 214-94-1858 Director UKRAINE Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ¥ Yes 2 □ No NY KINGS **BROOKLYN** Director 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code Itептя 23а 3033 CNY ISLAND AV 41 U.S.A Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc filed within 72 hours after 1 □ Never Married 2 □ Married 1 Yes 2 No WHITE ö Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: þ 3 Nidowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) NURSE MEDICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental I int; If itsm 27 is marked o NAUM GUREVICH **PASA** KUSHNIRSKAYA Nelionora Nelionora NELLA SOLOVYOVSKY/DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1814 RIDGEWAY AVENUE - LUTHERVILLE, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If its any injury or ot once. 1 Burial 2 Cremation 3 Removal from State CHIZUK AMUNO CONG. 08/03/2005 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between DAY 5 Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS /Medical Due to (or as a consequence of): DAYS **Examiner** ACUTE ON CHRONIC RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): YEARS DIABETES MELLITUS that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy Year in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? has irector, page 2 No No 1 ☐ Yes 1 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 X No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient P 1 🗌 Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mapner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death neral Director: A filled in by the fi Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D25886 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND 21204 OSLER DRIVE TOWSON. ILIA CEBALLOS M. D. 7601 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 4 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Margaret S. Beall July 2005 2:02 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Street Allegany

9. Birthplace (State or Foreign
Country) Cumberland
If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Dáys 1 ☐ M 2 🖫 F Hours Director 214-46-3666 105 Apr 16,1900 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ir than "natural", or itams 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Directo 1 X Yes 2 □ No Maryland Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Baltimore Street 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic more. Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Schwarzenbach Ella Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Glenn Beall-Son 44 Bealls Lane, Frostburg, MD 21532 20a. Method of Disposition July 27,2005 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Frostburg Mem. Pařk * 4 ☐Donation 5 ☐Other (Specify) Frostburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hafer Funeral Service, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, by Physician/Medical as the IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 21 No 2 No 1 Yes 1 Tyes 25. Was case referred to medical examiner?

1 X Yes 2 No (CLOSEC) Hospital: Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29d. Date, signed (Mofith, Day, Year) DOO 62429 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FAINLA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 0 4 2005

Richard Baenen

			Please			k Indelible Ink.			_	
AM.	ENDED i	tei	For 5& 31, TCHD, 07	5,2005,3	aryland / i sbb	Department of F Certificate of			ne .ND ∩ □	25100
	Physici /Medio		Decedent's Name (First, Middle, L RICHARD ANTHON	ast)			2	Date of Death Month	23 2000	3. Time of Death
	Examir Funeral Director	er	4a. Ficility Name (If not institution gives the second of	Hospi	Hall ge (In yrs. last bir 71	E	If Under 24 Hrs. 8 Hours Min. J	Date of Birth (Month, Day, Y	4c. County of Dear	th BOT thplace (State or Foreign punity) TH DAKOTA
	aryland show		10a. State 10b. County		10c. City, Tow			<u> </u>		10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show rount be notified at	recto	MD TALBO)T	ST.	MICHAELS 10f. Zip Code		100	. Citizen of What Co	XXYes 2 □ No
	23a or	ralDi	202 MULBERRY ST				.663		USA	rui ita y .
036	ages 1 and 2 should be filed within 72 hours after death with the Marylar It of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28e-1 show or other treumatic event, if a Madical Examiner must be milling at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces? 1 2 Yes 2 1 If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes ※☐ No	lispanic Origin? (Speci an, Mexican, Puerto Ric Specify:	y Yes or No- can, etc.)	14. Race - Ame Black, Whit Specify: W	
21215-0036	n 72 h	Completed	15. Decedent's E (Specify only highest g	Education rade completed)	16a	Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	ation during most of working	16	b. Kind of Business	Industry
	filed within Hygiene. other then o	Somp	Elementary/Secondary (0-12)	College (1-4or	5+)	LAWYER			LAW	
Maryland	tould be filed I Mental Hygi narkad othar natic evant, II	To Be (17. Father's Name (First, Middle, Las ARTHUR BAENEN					SCHOEF	ΓER	
	nd 2 sho alth and 27 is ma ir trauma		19a. Informant's Name/Relationship MICHAEL BAENEN/S			985 GOODWIN				₫p Code)
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or othar tra once.		20a. Method of Disposition 1 D Burial 2 X Cremation 3 (☐Removal from State	20b. Place o cemete	f Disposition (Name of ry, crematory or other place	Dat	9 20	c. Location - City or	
Itim	permit. Page Department of Important: if any injury or once.		' 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice	ify)	CHESA	PEAKE CREMAT	CION CTR 7/	25/2005	STEVENSV	ILLE, MD
Ba	Depar Depar Impor any ir		Joseph m. O	Stewast's	C.F. SA	FELLOWS, H 200 S. HAR	ss of Facility IELFENBEIN IRISON ST E	& NEWNAN ASTON, N	1 FUNERAL 1D 21601	HOME PA
60,	/Medical Examiner	cai Examiner	23a. Part1. Enter the disease, or cor shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if my learning to mine dialocause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Cinco a each ii Due to (or as	a consequence	on: Up 1 Blee		espiratory arrest		Approximate Interval Between Onset and Death
.O. Box 687	The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome	of pregnancy 2 Petal death	n 3 ⊟Ectopic pregnancy 5 □ Other (specify)			23d. Date of del Month	ivery Day Year
۵.	w requires that the bean signed by the should be detach	ed by Pł	Part II. Other significant conditions	contributing to death b	out not resulting i	n the underlying cause give	en in Part I.		co use contribute to	the cause of death?
Vital Records,		Be Completed	25. Was case referred to medical				26. Place of Death (prior to death?	utopsy findings available completion of cause of 2 No
of Vi	ys di	은	examiner? 1 ☐ Yes 2 X No	Hospital:			er: 4 🗆 Nursing Home		e 6 □Other (Spec	cify)
Division o	Jing After funei	Medical Certification:	27. Manner of Death Natural 5 Pending investigatic 3 Suicide 6 Could not determined	be	y Year)	Time of Injury 28c. Injury World 1 1	Yes 2 □ No	Describe how Location (Stree	at and Number or Ru	ural Route Number.
Di	ital or irs after rat Dire	Cert	4 Director	building, et	c. (Specify)			City or Town, S	State)	
	To the Hospital or Attand within 24 hours after death To the Funaral Diractor: completely filled in by the	Medical	one)	hysician: To the best miner: On the basis o and manner st	it examination ar	e, death occurred at the tin	pinion, death occurred	at the time, date	and place, and due	to the cause(s)
	To To		29b. Signature and title of certifier	Hatno	ni	29c. Licenso	53775	^{29d.}	uly 24	O G
13	STIVA		30. Name and address of berson who	completed cause of c		(Type, Print) U205hirztm	St FASTS	C. 1		
	Sta Registi		31. Date filed (Month, Day, Year)		ar's Signature	JUL 2	5 2005		k 42	ic.
DII	MIL 47 0 - 17			-		(E				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ivia		ertificate of	neaim and iv Death	, ,		
			Decedent's Name (First, Middle, Last)			Douin	2. Date of Death	g. No. 2005	32100 0 0000
	Physici		Janet E1	len 1	Brown			Month July	Day Year	9-25 AVM
	/Medic Examir		4a. Facility Name (If not institution, give		DIOWII	4b. City. Town.	or Location of Death	July	20, 2005 4c. County of Deat	8:25 AM ^M
	CAUTIT		Solomons Nursing	•		Solomo				
	Funeral		5. Social Security Number 6. Se		(In yrs. last birthday			8. Date of Birth	Calvert	
	Director		213-50-4194]M 2 X]F	59 Yrs.	Months Days	Hours Min.	June 13,		nplace (State or Foreign untry)
	ס		Usual Residence of Decedent					June 13,	1940 Ma.	ryland
	rylan how		10a. State 10b. County	1	10c. City, Town or I	ocation				10d. Inside City Limits
	Ma-f	tot	Maryland St. Ma	rv's		Califor	nia			1 ☐ Yes 2 No
	h the	ire	10e. Street and Number			10f. Zip Code	ii Lu	10	g. Citizen of What Cor	untry?
	h wit	Funeral Director	22996 Pine Needle	Court		206	19	7.	Inited Stan	tos
	deat ms	ner	11. Marital Status	12. Was Decedent E	ver in U.S. 13		Hispanic Origin? (Spe an, Mexican, Puerto		14. Race - Amer	ican Indian,
9	after or Ite	亞	1 Never Married 2 Married	Armed Forces? 1 Tes 2 No	0			Rican, etc.)	Black, White	
21215-0036	72 hours after death with the Maryland natural', or tlems 23a or 28a-1 show lical Evaril var must be motified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 █ No	Specify:		Specify: Wh	ite
2-0	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a. Dec	edent's Usual Occup	pation	16	6b. Kind of Business/l	ndustry
21	thin .	pje	Elementary/Secondary (0-12)	College (1-4or 5+	life	DO NOT use retire	during most of worki d)	ng		
21	er th	50		6		hic Desi	gner		Education	ı
pu	a Hy foth vent	Be (17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Ma	aiden Sumame)	
Maryland	uld b Menti rrked rrked	To	Edwin Donnally Br	own			Martha	Louise S	tine	
ary	sho and h s ms	•	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mai	ing Address (Street	and Number or Rura	l Route Number, (City or Town, State, Z	ip Code)
	alth a		Suzanne L. Patter	son / Sist					rnia, MD 2	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23s or 28s-f show any figury or other traumatic event, the Medical Exercities must be notified at ODGs.		20a. Method of Disposition		20b. Place of Disp	osition (Name of ematory or other pla			c. Location - City or 1	
e E	age ent o ht: If		1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		1		· 1	2005 01	arlotte Ha	11 10
≣	artm ortar inju		21. Signatura et Juneral Service	/ 1	prinsile	2. Name and Addre	os of Facility D	-2005 Cn	ariotte Ha	111, MD
Ba	permi Depar Impor		Edward N. Brinsile	~//	M00052 2	22955 Hol	Lywood Roa	nsfield .d, Leona	Funeral Ho	me, P.A. 20650-0279
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	r respiratory arres	t,	Approximate Interval Between				
	Physician		Immediate Cause (Final disease or condition	F.	+1 1da	Doney	tia			Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequence of):	0,000	7.00			
н	Examiner			•						
	-	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					-
	uted d ansit	盲	Cause. Enter Underlying Cause (Disease or injury that initiated events						1	
ć	exec n an ial-tr	Examlner	resulting in death) Last	Due to (or as a	consequence of):					
68760,	The law requires that the death certiticate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit									
.89	rtiticating phy	Medicai								
Вох	ndin use a		IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of					23d. Date of deliv	70.D/
ğ	death ce attendii	Physician/	in the past 12 months?	1☐Live birth 2 4☐Pregnant at ti		Dectopic pregnancy Other (specify)	′		Month	Day Year
o.	at the de by the tached	ys	9 Unknown	9□ Unknown						
σ.	es that igned b		Part II. Other significant conditions cor	tributing to death but	not resulting in the t	underlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Records,	uires sign ld be	d by								bably 4 □Unknown
õ	w requir been si should I	ete								
3ec	has has	Completed						24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
		ပ္ပ						performe	d? death? No 1 ☐ Yes	2510
Vital	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	la amita la			26. Place of Death			
of	Physician: this certific ral director,	မ	1 163 21010	lospital: 1 Inpatient			A Livursing Hon	ne 5 🗆 Residenc	ce 6 □Other (Speci	fy)
	ding P h. After tunera	on:	27. Manner of Death 12 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	of 28c. Injur Wor	y at 2 k?	8d. Describe how	injury occurred	
Sio	Attending or death. ector: After by the tuner	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 🗆	Yes 2 □ No			
Division	I or Atten after deatl Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, st (Specify)	reet, factory, office	2	8f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
	spitel or ours afte lerel Dir filled in	Se		1					,	
		edical	29a. Certifier 12 Certifying Phys (Check only one) 2 Medical Examin	nician: To the best of ner: On the basis of e and manner state	xamination and/or in	h occurred at the tir vestigation, in my o	ne, date and place, a pinion, death occurre	nd due to the caused at the time, date	se(s) and manner as s and place, and due t	stated. o the cause(s)
	To the Howithin 24 h To the Fur	Med	29b. Signature and title of certifier	7		29c. Licens			. Date signed (Month,	
	F ≯ F 8		8.11	To la N	2					
2	M		- sant y	1-000	"/		7610		Tuly 20,	2000
)	~		30. Name and address of persof who co							
			David J. Tardio, N			Road, Sui	te 310, P	rince Fre	ederick, M	D 20678
	Sta Registra	_	31. Date filed (Month, Day, Year) JUL 2 2 2005	3 Registrar		1				
	negisti	11	00L - 0 LUU,	A LAND COMPANY	AP AND					

/Med		1 - State Registrar 1. Decedent's Name (First, Middle, Last) Eleanor Tharp Green E	Cei	rtificate of Death	2. Date of Dea	Reg. No. 1 1 5 ath 2005 Yea	8:35a
Exami	ner	4a. Facility Name (If not institution, give street and number) 10153 Vantage Point Co	urt	Ab. City, Town, or Location of De New Market	ath	Freder	
Funeral Director		212-05-1980 1□M 2⊠F	e (In yrs. last birthday) 93 Yrs.	If Under 1 Year If Under 24 H Months Days Hours Mi		(1 ^Y 044) 2	Birthplace (State or Foreig Country) Charlotte,
yland Now		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limit
Ba-f st	ctor	MD Frederick	New Marl				1 ☐ Yes 2X N
with the	I Dire	10e. Street and Number 10153 Vantage Point Co	urt	10f. Zip Code 21774		10g. Citizen of What USA	Country?
ING KILIS-UUSO be filed within 72 hours after death with the Maryland tlat Hygiene. dother than "natural", or Items 23a or 28a-1 show event, the Medical Examinar must be recitified at	/ Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes, Give	No	Mas Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Pue □ Yes 2 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Ar Black, W	
Z I Z I 3-0030 of within 72 hours af giene " er then "natural", or the Medical Exem	Completed by	3 □ Note dear or Dates: 15. Decedent's Education				16b. Kind of Busine	
within 7 ene. then r	mple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5)+)	dent's Usual Occupation kind of work done during most of w DO NOT use retired)	orking	**	
il Hygie other	Be Co	12 years 17. Father's Name (First, Middle, Last)	НОШЕ	emaker 18. Mother's N	ame (First, Middle,	Home Maiden Sumame)	
Should be ind Mental I	ToB	William Howard Green		May 7			
IOCE, Maryland ges 1 and 2 should be file t of Health and Mental Hy If flem 27 is marked oth or other traumatic event		19a. Informant's Name/Relationship (Type, Print) William W. Banks, Jr.(19b. Mailir son) 101	ng Address (Street and Number or 1 153 Vantage Po	Rural Route Numbe	r, City or Town, State rt. New M	^{, Zip Code)} 21774 larket.Md
Baltimore, Misper trand 2 Department of Health a Department of Health a Department: If them 27 is any injury or other tra		20a. Method of Disposition 1 ☐ Burial 2 ☑ remation 3 ☐ Removal from State	20b. Place of Dispo		Date	20c. Location - City	
Dallimore, berrit. Pages 1 a Department of Hes mportant: if them any injury or othe		*4 □Donation 5 □ Other (Specify)	Capitol	Crematory 7-2		•	
perrit. Pa Departmen Important: any injury		21. Signature of Funeral Service Licensee	$\int_{\mathbb{R}^{2}} \int_{\mathbb{R}^{2}} \frac{22}{1}$	Name and Address of Facility Carroll Hur	ley Fun	eral Hom	e, PC
Physician /Medical Examiner prize pr	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of): 9 es twe a consequence of): a consequence of):	Avery Dise Heart For	ine		Interval Between Onset and Death
certificate be extending physician use as the buria	cal						
the death cert by the attendin	nysician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of o Month	lelivery Day Year
. ≂ ≳ಜ	by P	Part II. Other significant conditions contributing to death b	ut not resulting in the u	nderlying cause given in Part I.			to the cause of death? Probably 4 Munknow
ires that the signed by I be detac		Hypertension		5.9 6.60	24a. Was a		Productly 4 Conknown
Ords, r	letec				autop	sy prior t	autoney findings available
The lay	Completed by Physician/Med				perfor	med? death 2√No 1 ☐ Y	o completion of cause of
VICAL DEVICION: The law certificate has rector, page 2	Be	25. Was case referred to medical examiner?		26. Place of D	perfor 1 Yes	2 No 1 Y	o completion of cause of es 25 No
VICAL DEVICION: The law certificate has rector, page 2	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatie 27. Manner of Death 28a. Date of Injure	nt 2□ER/Outpatien	26. Place of D	perfor 1 Yes eath (Check only or Home 5 Aesid	2 No 1 Y	o completion of cause of es 25 No
VICAL DE LA LICIAN: The lav certificate has rector, page 2	To Be	25. Was case referred to medical examiner? 1 Yes 2 Hospital: 1 Inpatie 27. Manner of Death 1 Altural 5 Pending 2 Accident investigation 2 Suicide 6 Could not be	nt 2 ER/Outpatien ry Year) 28b. Time of Injury ury - At home, farm, str	26. Place of D t 3 DOA Other: 4 Nursing 28c. Injury at Work? M 1 Yes 2 No	perfor 1 Pes Peside Pes	2 No 1 Yourseld	o completion of cause of nest and nest
VICAL NE (sician: The latector, page 2	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 Hospital: 1 Inpatial: 1 In	int 2 ER/Outpatien 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury	26. Place of D t 3 DOA Other: 4 Nursing 28c. Injury at Work? M 1 Yes 2 No eet, factory, office	Performance of the control of the co	2 No 1 Yourseld 1 Your	o completion of cause of pas 2 No pecify) Rural Route Number,
OI VICAL NEO Physician: The lav this certificate has ral director, page 2	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatie 27. Manner of Death 1 Altural 5 Pending investigation 3 Suicide 6 Could not be determined 28e. Place of Inju (Month, Da) building, et 29a. Certifier (Check only) 29d. Medical Examiner: On the basis of	int 2 ER/Outpatien 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury	26. Place of D t 3 DOA Other: 4 Nursing 28c. Injury at Work? M 1 Yes 2 No eet, factory, office	Performance of the course of at the time, of the course of	2 No 1 Yourseld 1 Your	as 2 No pecify) Rural Route Number, as stated. ue to the cause(s) nth, Day, Year)
vician: The lar certificate has	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ont 2 ER/Outpatienry Year) 28b. Time of Injury ury - At home, farm, stroperity of my knowledge, deatt examination and/or insted.	26. Place of D t 3 DOA Other: 4 Nursing 28c. Injury at Work? M 1 Yes 2 No eet, factory, office 29c. License number 29c. License number	perfor 1 Yes eath (Check only or Home 5 Aesid 28d. Describe h 28f. Location (S City or Tow	2 Alo 1 Yes	o completion of cause of pas 25 No pecify) Rural Route Number, as stated. ue to the cause(s)

			For State	State of Marylar	_	artment of He			000	·	
			Registrar 1. Decedent's Name (First, Middle, Las.	t)	- 001	tillcate of D	Call	2. Date of Death	No.	5 3	Time of Death
	Physici		Edward	Powell	Beat	- +		July 16	Day 200	Year C	9:00 a M
	/Medic Examin		4a. Facility Name (If not institution, give		Беа	4b. City, Town, or L	ocation of Death	July 10	4c. County of		7.00 a
	=Xaiiiii		50 Appeal Lane, A	pt. 325		Lusby			Cal	vert	
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ar)	9. Birthplace	(State or Foreign
	Director		5/9-52-0181	ZM 2□F 66	Yrs.	World Days	TICOTS IVIII.	Feb 23,	1939	Wash.	D.C.
pue	* -		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d.	Inside City Limits
Vary	a Pie	0	MD Calvert			Lusby	•				1 ☐ Yes 2 X No
đ	288	rec	MD Calvert			10f. Zip Code		10g	Citizen of Wh	nat Country?	?
ži.w	3a o	0	50 Appeal Lane, A	pt. 325		20657			USA		
	swe	Funeral Director	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Spe	ecify Yes or No-		- American I	
و الم	a a		1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give		1 ☐ Yes 21 ∑ No	Specify:	riidari, etc.)	Specify:	White, etc.	
	ural',	d by	3 ☐ Widowed 4 🏋 Divorced	Year or Dates:						whit	
5	nat	Completed	15. Decedent's Ed (Specify only highest grad		(Give	dent's Usual Occupati kind of work done du DO NOT use retired)	ion <i>ring</i> most of worki	ing 16	o. Kind of Bus	iness/Indust	ry
. id	than	шо	Elementary/Secondary (0-12)	College (1-4or 5+)		ing clerk,	truck d	river	pet		
ING Z. I.Z. 13-0030 he filed within 72 hours after death with the Maryland	Hyg othar	BeC	17. Father's Name (First, Middle, Last)		тыптрр.			(First, Middle, Mai)	
	Aenta rkad tic ay	To B	Carl William	Beatty			Lillian	Gertru	ıde	Fishe	r
Mary 12sh	and h		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (Street an	d Number or Rura	al Route Number, C	ity or Town, S	tate, Zip Co	de)
e	m 27 m 27 nar tr		Carl W. Beatty, J	r., brother		Lake Shor					
	penium ragge range should be manyim represented by the should be because the should be because the should be because the should be because the should be because the should be s		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐	Removal from State	cemetery, crei	osition (Name of matory or other place))		c. Location - C		
	ttmen rtant: njury	19	* 4 □ Donation 5 □ Other (Specify) Me		itan Crema		9-05 Al	exandr	ia, W	A
	Depa Impo any ir		21. Signaturi of Funeral Service Licen	500		2. Name and Address	•	- D 7	~ .d	. 340	20726
			23a. Part1. Enter the disease, or comp	alication what caused the dea		Rausch Fun					20736
			shock, or heart failure. List only of Immediate Cause (Final	one cause on each line	4			in respiratory arrest	,	Int	erval Between eset and Death
	nysician /Medical		disease or condition resulting in death)	a. Due to (or as a conse	dience off.	rare 10	?				
E	xaminer			a. Myarardi Due to (or as a conse	0-1	ido Mell	tus				
		ner	Sequentially list conditions, cause. Enter Underlying	Due o (or as a cons	cheuce of:	,					
a til	ind	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Hypertens							
ou, be executed	physician and the burial-transit	E	rosoning in death) East	Due to (or as a conse	quence ot):						
0 5	physi	dlcal		d							
o xo	been signed by the attending p should be detached for use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn	nancy				23d. Date	of delivery	
XOU .	atter d for u	Physician/M	in the past 12 months?	1☐Live birth 2☐Fet 4☐Pregnant at time of		∃Ectopic pregnancy ∃ Other (specify)			Mont		y Year
ַ פַ	by the	hys	9 Unknown	9□ Unknown							
ords, P	gned gned	by P	Part II. Other significant conditions co	ontributing to death but not re	sulting in the u	nderlying cause given	in Part I.	23e. Did tobac	co use contrib	oute to the c	ause of death?
Records	equili							1 Tes	280 No 3	Probably	y 4 □Unknown
O 3	a S C	ompleted						24a. Was an autopsy	pri	ere autopsy ior to comple	findings available etion of cause of
_ ⊢	ate	Co						performe 1 □ Yes 2 🔀		ath?]Yes 2[] No
OT VITAL	is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:				(Check only one)			
5	rthis rat di	: To	1 ☐ Yes 2 X No	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatier 28b. Time o			me 5X Residence 28d. Describe how			
SION	th. After the funeral	tlon	Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work?	es 2 □No		injury cocurro		
VISI	after death. I Diractor: After id in by the funer.	Ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At I	nome, farm, str	reet, factory, office	Ī	28f. Location (Stree		or Rural Ro	oute Number,
בּ בּ	hours after death. unaral Diractor: A	Certification;	4 🗆 nomicide	building, etc. (Spec	ny)			City or Town, S	itate)		
1000		Medical	29a. Certifier Certifying Phyone) Check only 2 Medical Example 1	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurred at the time vestigation, in my opi	, date and place, nion, death occurr	and due to the caus ed at the time, date	e(s) and man and place, ar	ner as stated and due to the	d. e cause(s)
70.5	within 24	Me	29b. Signature and title of certifier	10		29c. License		29d	Date signed	(Month, Day	r, Year)
			1 Done of	Torolo MD		247	610	J	1, 18	20	005
	1		30. Name and address of person who d								
	9		David J. Tardio,			s. Rd., St	e 2500,	Solomons	MD 20	688	-
	Sta Regist		31. Date filed (Month, Day, Year) JUL 2	32. Registre's Sign	is the	bette					

amend 21 per hosp 28/6. 6/4/05 KRH Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 19:25 PM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ROCKVILE, MARYLAND

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Davs | Hours | Min. | Month, Day, Year) GROVE ADVENTIST MONTGOMERY 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Yrs. MARYLAND Director NONE Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and them 17 le marked other then "naturel", or Items 23a or 28e-1 show 10c. City, Town or Location 10a State 10d. Inside City Limits f Health and Mental Hygiene. item 27 le marked other then "naturel", or Items 23a or 28e-1 show other treumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No POTOMAC NORTH Completed by Funeral Director MD MONTGOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #919 OUTPOST DRIVE 20878 11042 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced LHINESE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) INFANT INFANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FENG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DRIVE #919, NORT POTOMAC ENG MEI FATHER 11042 OUTPOST 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Importent: If it eny injury or o once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) MORGANTOWN, PA CYCLE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ENTER DRIVE, KOCKVILLE Micheal Franklin (perDVR) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician HORIOAMNIONITIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? λq Division of Vital Records, No. 3 ☐ Probably 4 ☐ Unknown 1 🗆 Yes Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 2∏ No 1 TYes Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation rector: 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Direc 4 / Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Fun completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mi D0012878 tho completed cause of death (Item 23a) (Type, Print) SHADY GROVE ADVENTIST, 9901 MEDICAL CENTER DR. ROCKVILLE 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

AUG 0 4 2005

			1 - For State of Maryland / Dep	eartment of Health and Mertificate of Death		2005	25494		
	Physicia	an	1. Decedent's Name <i>(First, Middle, Last)</i> Joan Katherine Cahill		2. Date of Death July 14 ^D	^{ay} 2005	3. Time of Death 7:00 AM		
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death			
			914 Hickory Circle	LaPlata If Under 1 Year If Under 24 Hrs.		Charles			
	Funeral Director		5. Social Security Number 6. Sex 1 \square M 2 \square 7. Age (In yrs. last birthday, 77 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year nber 16,	1927 Mas	place (State or Foreign Intry) Ssachusett		
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits			
	Maryl B-f sho	tor	MD Charles LaPla	ata			1 XYes 2 ☐ No		
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "neturel", or Items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	Funeral Director	10e. Street and Number 914 Hickory Circle	10f. Zip Code 20646	10g. C	itizen of What Cou USA	intry?		
	ter dea	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rac Blac							
900	ours af	by	1 ⚠ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give ⚠ Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: V	Vhite		
15-0	n 72 h	ietec	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of worki DO NOT use retired)	ng 16b.	Kind of Business/Ir	ndustry		
212	e filed within al Hygiene. i other than " vent, Ine Mes	Completed	Flementary/Secondary (0-12) College (1-4or 5+)	eacher		Home E	conomics		
Maryland 21215-0036	ould be file Mental Hy arked oth	To Be (17. Father's Name (First, Middle, Last) William E. Cahill		ine M. Ca				
Mary	12 should be h and Mental 7 is marked raumatic ev	•	_	ling Address (Street and Number or Rura					
	s 1 and f Health Item 27 other tr		20a. Method of Disposition 20b. Place of Disp	Hickory Circle		A, MD 20 Location - City or T	0646 own, State		
Baltimore,	Pages ment of lient; If Its ury or o		1 □ Burial 2 Other (Specify) 1 □ Burial 2 Other (Specify) 1 □ Burial 2 Other (Specify)	eld-Echols 7/15/	05 Char	clotte H	Hall,MD		
Balt	permit. Depart Import any inj	E E E							
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final	nter the mode of dying, such as cardiac of	r respiratory arrest,		Approximate Interval Between Onset and Death		
	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of):	ne to thrive					
	Examiner	lue .	Sequentially list conditions, b. Due to (or as a consequence of):	mphedemo					
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	,					
90,	icate be executed physician and s the burial-transit		resulting in death) Last C. Due to (or as a consequence of):						
68760,	ficate t physics ts the b	edica	d						
Вох	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	□Ectopic pregnancy		23d. Date of deliv			
0	at the dea by the al	ıysici	1 □ Pes 2 No 4 □ Pregnant at time of death 5 (9 □ Unknown	Other (specify)		Month	Day Year		
S, D	requires that een signed b nould be deta	by Pł	Part II. Other significant conditions contributing to death but not resulting in the t	underlying cause given in Part I.		_	the cause of death?		
ord	v requir been s should	eted			1 Yes				
of Vital Records,	The lay te has age 2	Completed			24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of		
/ital	Physician: this certifica ral director, p	Be	25. Was case referred to medical examiner?	26. Place of Death					
	Phys this ral di); To	1		ne 5 Residence 28d. Describe how inj		fy)		
sion	Attending I r death. ector: After by the funer	atio	1 SNatural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 □ Yes 2 □ No					
Division	in Dire	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office	28f. Location (Street a City or Town, Sta		al Route Number,		
	To the Hospital or within 24 hours afte To the Funerel Dir completely filled in	edical C	29a. Certifler (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, anvestigation, in my opinion, death occurr	and due to the cause(ed at the time, date ar	s) and manner as s nd place, and due t	stated. o the cause(s)		
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number		ate signed (Month,			
•			30. Name and address of person who completed cause of death /liam 22s \ Time	D45737		7114/05	>		
Col	B3		30. Name and address of person who completed cause of death (Item 23a) (Type N. Jayanthan, M.D. 3328 01d Was	shington Rd. Wal	.dorf,MD	20602			
	Sta Registr	1111 7 5) 2007 h // A							

		,	1 - For Stete Registrar	State of Ma	arylan		rtmen tificat			ind M		giene	005	2	5495	,
	Physicia	an	Decedent's Name (First, Middle, Las WILLIAM H. CORK								2. Date of Dea Month JULY	ath Day 25	20 [°] 0	¥	3. Time of Death 12:55PM	
	/Medic Examin	Zi.	4a. Facility Name (If not institution, give	street and number)			-	Town, or	Location o	f Death	3011		County of D	eath	12.55111	
	Funeral Director	Director 711-07-7719 12 M 2 F 85 Yrs. Months Days Hours Min. FEB 27 1920 Usual Residence of Decedent									9. M		hirthplace (State or Foreign Country) RYLAND			
	Maryland f show	tor	10a. State 10b. County MD TALBOT		10c. Cit	y, Town or Lo								100	d. Inside City Lim	
:	or 28a- or 28a- o notil	MD TALBOT TRAPPE 10e. Street and Number 10f. Zip Code 10g. Citizen of V								en of What	Countr	y?				
	4050 CLORA DORSEY RD 21673 U								USA							
9	be lied within 72 nours after deeth with the Maryland lat Hygiene. Ad other than "naturel", or Items 23a or 28a-f show event, it a Madical Exaction in that be notified at	d by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Xes 2 1 If Yes, Give Year or Dates:		1	Vas Dece fYes, spe I ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: WHITE			
12.	within 72 h ene. than "natu	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12	ucation de <i>completed)</i> College (1-4or 5	5+)	life. L	lent's Usu: kind of wo DO NOT u NGINE	rk done a se retired,	lurina most	of workii	ng		od of Busine			
ומוומ	Z should be filed within and Mental Hygiene. Is marked other than aumatic event, It a Ma	To Be Co	17. Father's Name (First, Middle, Last) WILLIAM H. CORKE	AN, SR.			NOTIL				(First, Middle, BARTLE)	Maiden S			110	
= 1			19a. Informant's Name/Relationship (7 BEVERLY C. EDGELI			1					Route Number				Code)	
	Pages 1 and nent of Health int: If item 27 iry or other tr		20a. Method of Disposition 1 X Burial 2 Cremation 3 C		C	Place of Dispo	natory or c	ther place			/2005		ation - City			
	permit. P Departme Importan any injuri once.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility FET.T.OWS. HET.FENBETN & NEWNAM F														
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	MERCE									21601	1	Approximate	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	ale	Ca	nco							0	nterval Between Onser and Death	2
ı.	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a conseq	uence of):										
5	icate be executed physician and s the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a conseq	uence of):										
0	Tificate	Medic	15.55.111.5	d												
	o the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours either death. Or the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	Ideath 3	Ectopic pi Other (sp					2	3d. Date of Month		/ ∂ay Year	
L (CD	quires that the de n signed by the a uld be detached f	by	Part II. Other significant conditions co	ontributing to death b	ut not res	ulting in the ur	nderlying o	ause give	en in Part I.			obacco us		e to the	cause of death?	
200	ician: The law requir certificate has been si rector, page 2 should I	Completed											24b. Were prior death	1?	sy lindings availa pletion of cause o	ble
<u> </u>	clan: artifica actor, p	BeC	25. Was case referred to medical examiner?							ol Death	(Check only o					
5	Physic this co	2	1 Yes 2 No	Hospital: 1 ☐ Inpatie		ER/Outpatien			4 🗆 Nui		ne 5 X Resid			(pecify		
5	nding Fath. ath. r: After e funera	ation	1. Natural 5 Pending 2 Accident Investigation	28a. Date of Inju (Month, Da	y Year)	Injury	м	Bc. Injury Work	? /es 2 🗆 t		.bu. Describe I	iow injury	occurred			
	To the Hospital or Attending Physician: The lay within 24 burus elter death. To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, et	ury - At ho c. (Specif	ome, farm, str	eet, factor	y, office		2	28f. Location (S City or Tow	Street and m, State)	f Number or	Rural	Route Number,	
	To the Hospita within 24 hours To the Funeral completely filled	Medical (29a. Certifier Certifying Phyone) 2 Medical Exem	/sician: To the best iner: On the basis o and manner st	1 examina	wledge, death	occurred vestigation	at the tim , in my op	e, date and pinion, deat	d place, a	and due to the dead at the time, d	cause(s) a date and	and manner place, and	as stat	ted. he cause(s)	
	To the within To the comp	Me	29b. Signature and tine of certifier	1 Sumh		/	290	c. License	number 988	7		29d. Date	26 /	of th. Di	ay, Year)	
1	2		30. Name and address of person who o				,			1601		4				
	2+1VA Sta	ate	DAVID SMITH M.D 31. Date liled (Month, Day, Year)	32. Registr			EAS	TON,	MD 2.	1001						
	Pagist		JUL 2 7 200!		A	4										

David Lee Campbell 05-04847 NJM Physicia /Medic Examin , Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or itsms 23s or 28s-1 show sny Injury or out or traumatic event, it is Medical Examination rust be neitified at once. Baltimore, Maryland 21215-0036 **Physician** /Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	7 State Registrar	Cei	rtificate of l	Death		Reg. No.	000	1.7				
	1. Decedent's Name (First, Middle, Last)				2. Date of De		000	3. Time on Death				
n	David Lee Campbell				July	18	2005	0338 м				
al er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Dea		4c. Count	y of Death					
	Route 70 @ Mile Marker 39.5		Myersv	ille		Fred	erick					
т	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hr		th		ace (State or Foreign				
	212-68-2812 XM 2 F	48 Yrs.	Months Days	Hours Mir	April 2	26° 1957	Virg	ace (State or Foreign nia				
	Usual Residence of Decedent			<u> </u>	F	,	1 1 5					
	10a. State 10b. County 1	Oc. City, Town or Lo	cation				10	d. Inside City Limits				
ŏ	Maryland Calvert	St. Lec	onard					1 ☐ Yes 2 ☐No				
Sec.	10a. Street and Number		10f. Zip Code			10g. Citizen of	What Countr	rv?				
٥	5835 Valley Drive			865		United						
era	11. Marital Status 12. Was Decedent Ev.	orio II 6 12 1	Non Doordont of Li	innania Orinia 2 /	Cased Van an Na	14 De		a la dia -				
Š	Armed Forces?	BI III O.S. 13. 1	Was Decedent of Hi f Yes, specify Cuba	in, Mexican, Pue	nto Rican, etc.)	Bla	ce - America ack, White, e					
×	1 Never Married 2 Married 1 Yes 2 No 1 Yes, Give 1 Yes, Give Year or Dates:		1□Yes 2XNo	Specify:		Speci	íy:	White				
Completed by Funeral Director		160 Daniel		-A:		101 151 1 - 6 5						
et	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of we	orking	16b. Kind of E	Business/Indu	istry				
E.	Elementary/Secondary (0-12) College (1-4or 5+)		ry Worker	•		Printi	ing Co.					
ပိ	17. Father's Name (First, Middle, Last)	Dirides	TY NOTACE		(F)			•				
To Be	Reuben Campbell			Violet	ame (First, Middle, Davis	Maiden Suma	me)					
2				110100	Davis							
	19a. Informant's Name/Relationship (Type, Print)		ig Address (Street a	and Number or F	Rural Route Numbe	er, City or Town	, State, Zip C	Code)				
	Elizabeth Anne Riggins -siste	er 9014	Rhode Is	land Ave	enue,#301	Collec	ge Parl	k, Md.2074				
	20a. Method of Disposition	20b. Place of Dispo	sition (Name of natory or other plac	اام	Date	20c. Location	- City or Tow	m, State				
	1 ☐ Burial 2 ☐Cremation 3 ☐Removal from State 4 ☐Donation 5 ☐ Other (Specify)	Metropoli	itan Crem	atory 7,	/19/2005	Alexand	dria, V	Virginia				
	21. Signature of Funeral Service Licensee	_22	Name and Addres	ss of Facility								
	Ilameld V. Romerone	loc IX	Name and Address DnaId V. 100 Powde	Borgward	it Funera	ı⊥ Home,	PA	20705				
-	23a. Part1. Enter the disease, or complications that caused th							20705 Approximate				
	shock, or heart failure. List only one cause on each line.	e delin. Do not onto	ar tria mode or dynn	g, such as cardie	ac or respiratory a	1631,	1	nterval Between Onset and Death				
	Immediate Cause (Final disease or condition	with his	ance					Dog and Dog and				
	Due to (or as a consequence of):											
	Sequentially list conditions, b											
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ronsequence of):										
E	that initiated events											
X	resulting in death) Last Due to (or as a c	consequence of):										
edicai Examiner	d											
ed			Lane some									
2	IF FEMALE: 23c. If yes, outcome of					23d. Da	ate of delivery	,				
cla	in the past 12 months? 1 ☐ Yes 2 ☐ No 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tin		lEctopic pregnancy Other (specify)			M	onth D	ay Year				
hysiciar	9 Unknown											
₾.	Part II. Other significant conditions contributing to death but I	not resulting in the ur	nderlying cause give	en in Part I.	23e. Did t	obacco use con	tribute to the	cause of death?				
d by					10.	res 2□No	3 ☐ Probat	bly 4 Dnknown				
ete								(
Completed					24a. Was autor	SV	prior to comi	sy findings available pletion of cause of				
Ö						med? 2□No	d ath? 1AC es 2	□No				
Be	25. Was case referred to medical examiner?			26. Place of De	ath Ch ck only o	ne)	•					
	1 ☑ Yes 2 ☐ No Hospital: 1 ☐ Inpatient	2 ER/Outpatien	t 3 DOA Othe	er: 4 ☐ Nursing	Home 5 Resid	dence 6 🖾 Ot	her (Specify)	Scene				
ü	27. Manner of Death 28a. Date of Injury	28b. Time of Injury	28c. Injury Work	at	28d. Describe I	now injury occu	ten					
atic	1 □Natural 5 □ Pending 2 □ Accident investigation (Month, Day 1		M, 10	Yes 2 No	Land I	ic com	4000	i con				
<u>=</u>	3 Suicide 6 Could not be 28e. Place of Injury	- At home, farm, stre	eet, factory, office		28f. Location (Street and Num	ber or Rural I	Route Number,				
er	4 Homicide soloniand building, etc. (1 -duz	S		City or rov	vn, state)	Thomas	Rout 70 h				
ai	29a. Certifier 1 Certifying Physician: To the best of a	ny knowledge, death	ocsurred at the tim	ne, date and place	e, and due to the	cause(s) and m	anner as stat	and and				
edical Certification: To	(Check only and manner state) (Check only one) 2 Medical Examiner: On the basis of eyer and manner state	camination and/or inv	estigation, in my op	oinion, death occ	curred at the time,	date and place,	and due to the	he cause(s)				
Me	29b. Signature and title of certifier		29c. License	e number		29d. Date signe	ed (Month. Di	av. Year)				
	10 10 7/2 0											
	produce N. 107 -	w	OCM	Œ		July,	18, 20	005				
	30. Name and address of person who completed cause bit deal					_						
	THE DOOLL TOUR	nn Stree	er patti	Lmore,	Marylar	nd 2120	01					
е	31. Date filed (Month, Day, Year) 32 Registrar's	Signature	de									
	UUL GIL CUUL PTARELLE	AS AND	100									

State

Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Registrar DHMH 17 Rev 1/2001

ORIGINAL

NATHAN A. COHEN NATHAN A. COHEN			State Registrar 1. Decedent's Name (First, Middle, La)	acti		Cei	tificate o	Death	2, Date of De	Reg. No	2005	251,0
SUBUREAN HOSPITAL SUBUREAN HOSP	cian				COHEN				Month	Day		1:15 P
Scale Security Number December Part P							4b. City, Town	or Location of Deat	h	4c.	County of Dea	ath
December Part December De		_				. 4 5 3 5 3 - 1			0.0.1/5:	_		
23a. Part1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Bew interv		C	092-05-6432	·V					(Month Da	v Year)	C	ountry) W York
23a. Part I. Enter the disabelian or completion shall caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate finite and disabelian or completed cause (Pinal Information and the mode of dying, such as cardiac or respiratory arrest. Approximate finite and such the such that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate finite and such that interval Baw int		1	10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City L
Specify Spec	ctor	M	Maryland Montgom	ery	Ro	ckvil	Le					1 Tyes 2
23a. Part I. Enter the disable or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate fineway flaw in the cause of the cause of anothine. Approximate fineway flaw in the cause of the cause of anothine. Approximate fineway flaw in the cause of the cause of anothine. Approximate fineway flaw in the cause of the cause of anothine. Approximate fineway flaw in the cause of the cause of anothine fineway flaw in the cause of anothine fineway flaw in the cause of the cau	Dire	1			"					10g. Citi	izen of What C	ountry?
23a. Part I. Enter the disable or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate fineway flaw in the cause of the cause of anothine. Approximate fineway flaw in the cause of the cause of anothine. Approximate fineway flaw in the cause of the cause of anothine. Approximate fineway flaw in the cause of the cause of anothine. Approximate fineway flaw in the cause of the cause of anothine fineway flaw in the cause of anothine fineway flaw in the cause of the cau	e a	-				12.1			nooih. Voc or No			
23a. Part I. Enter the disagrador or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate the way flew interest and the cause of mach the interest flew and the cause of mach the interest flew and the cause of mach the interest flew and the cause of mach the cause of mac	Fun			Armed Forces?		. 13. 1	Yes, specify Cu	ban, Mexican, Puer	to Rican, etc.)			
23a. Part I. Enter the disable or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate fineway flaw in the cause of the cause of anothine. Approximate fineway flaw in the cause of the cause of anothine. Approximate fineway flaw in the cause of the cause of anothine. Approximate fineway flaw in the cause of the cause of anothine. Approximate fineway flaw in the cause of the cause of anothine fineway flaw in the cause of anothine fineway flaw in the cause of the cau	by	•		IT Yes, Give		I '	I∐Yes 21XIN	Specify:			Specify:	White
23a. Part I. Enter the disagrador or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate the way flew interest and the cause of mach the interest flew and the cause of mach the interest flew and the cause of mach the interest flew and the cause of mach the cause of mac	eted		15. Decedent's E (Specify only highest g:	Education rade completed)		(Give	kind of work don	e during most of wo	rking	16b. Ki	ind of Business	s/Industry
23a. Part I. Enter the disagrador or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate the way flew interest and the cause of mach the interest flew and the cause of mach the interest flew and the cause of mach the interest flew and the cause of mach the cause of mac	m	•	Elementary/Secondary (0-12)		5+)	life. l	OO NOT use reti	ed)			D - 6 - 11	
23a. Part I. Enter the disagrador or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate the way flew interest and the cause of mach the interest flew and the cause of mach the interest flew and the cause of mach the interest flew and the cause of mach the cause of mac	ပိ						witer	18. Mother's Nar	me (First, Middle,	Maiden		
23a. Part 1. Enter the disabelies or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Baw int	o Be							1110000				
23a. Part 1. Enter the disabelies or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Baw int	-		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Stree	at and Number or Ri	ıral Route Numbe	er, City o	r Town, State,	Zip Code)
23a. Part 1. Enter the disagle for compfications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Baw inter		5	Susan Moskowitz -	daughter		14237	Seclude	d Lane, N	. Potoma	ic, N	4D 208	78
23a. Part I. Enter the disagrador or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate the way flew interest and the cause of mach the interest flew and the cause of mach the interest flew and the cause of mach the interest flew and the cause of mach the cause of mac		2		Regional from State	20b. Pla	netery, cren	sition (Name of natory or other p	ace)	Date	20c. Lc	ocation - City or	Town, State
23a. Part I. Enter the disagrador or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate the way flew interest and the cause of mach the interest flew and the cause of mach the interest flew and the cause of mach the interest flew and the cause of mach the cause of mac			'4 □ Donaylon 5 □ Other (Spec	city	MT.							ARYLAND
23a Part Enter the disasted or complications that caused the feath. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate cause of each interval Betwook, or heart failure but only one cause on each interval Betwook, or heart failure but only one cause on each interval Betwook Onset and Di 12 hour feath but of as a consequence of):			1	nsee		EĎ1	VARDand Add	EL FUNERA	L DIRECT	TION	, INC.	20852
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and it is a consequence of):		+	23a. Part1. Enter the disease or con	mplications that caused	the death.						2, III	Approximate
Presulting in death) Presulting in death) Presulting in death Presulting in deat			Immediate Cause (Final			Failur	٠.					Onset and Dea
Sequentially list conditions, and it conditions, and it cause. Enter underlying cause. Enter underlying cause. Enter underlying cause. Enter underlying cause (Disasas or injury that initiated events insulting in death). Last statisting in death). Last statisting in death Last IFFEMALE: 236. Was decodent pregnant in the pass 12 months? 1 1 1 1 1 1 1 1 1	ı											12 11041
Cause Enter Underlying Cause (Disasse or injury resulting in death) Last FFEMALE: 23b. Was deadednt pregnant in the past 12 months? 1 1 1 1 1 1 1 1 1			Sequentially list conditions,	D								1 day
FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Yes 23d. Date of delivery Month Day Yes 23d. Date of delivery Month Day Yes 23d. Date of delivery Month Day Yes 23d. Date of delivery Month Day Yes 23d. Date of delivery Month Day Yes 23d. Date of delivery Month Day Yes 23d. Date of delivery Month Day Yes 23d. Date of delivery Month Day Yes 23d. Date of delivery Month Day Yes 23d. Date of delivery Month Day Yes 23d. Date of delivery Month Day Yes 23d. Date of delivery Month Day Yes 23d. Date of delivery Month Day Yes 23d. Date of delivery Month Day Yes 23d. Date of delivery Month Day Yes 23d. Date of death 1 Yes 22d. No 3 Probably 4 Urse 23d. Date of Death 1 Yes 22d. No 3 Probably 4 Urse 23d. Date of Death 1 Yes 22d. No 3 Probably 4 Urse 23d. Date of Death 1 Yes 22d. No 3 Probably 4 Urse 23d. Date of Death 1 Yes 22d. No 3 Probably 4 Urse 23d. Date of Death 1 Yes 22d. No 3 Probably 4 Urse 23d. Date of Death 1 Yes 22d. No 3 Probably 4 Urse 23d. Date of Death 1 Yes 22d. No 3 Probably 4 Urse 23d. Date of Death 1 Yes 22d. No 3 Probably 4 Urse 23d. Date of Death 1 Yes 22d. No 23d. Date of Death 1 Yes 22d. No 23d. Date of Death 1 Yes 22d. No 23d. Date of Death 1 Yes 2 No 23d. Date of Death 1 Yes 2 No 23d. Date of Death 1 Yes 2 No 23d. Date of Death 1 Yes 2 No 23d. Date of Death 1 Yes 2 No 23d. Date of Death 1 Yes 2 No 23d. Date of Death 1 Yes 2 No 23d. Date of Death 1 Yes 2 No 23d. Date of Death 1 Yes 2 No 23d. Date of Death 1 Yes 2 No 23d. Date of Death 1 Yes 2 No 23d. Date of Death 1 Yes 2 No 23d. Date of Death 1 Yes 2 No 23d. Date of Death 1 Yes 2 No 23d. Date of Death 1 Yes 2	lne		cause. Enter Underlying		_							
FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Yes 2 No 9 Unknown 9 Unknown 9 Unknown 23d. Date of delivery Month Day Yes 2 No 9 Unknown 23d. Date of delivery Month Day Yes 2 No 9 Unknown 23d. Date of the cause of death 1 Yes 2 No 3 Probably 4 Unknown 24d. Were autopsy findings an autopsy performance of the cause o	xan	1	that initiated events	U			n					
FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 1 1 1 1 1 1 1 1	Sai			e d								
25. Was case referred to medical examiner? 1 Yes 2 No 3 Probably 4 Under the cause of death of death of de	edic	-										
25. Was case referred to medical examiner? 1 Yes 2 No 3 Probably 4 Under the cause of death of death of de	an/N		23b. Was decedent pregnant				Ectonic pregnan	CV		1		
25. Was case referred to medical examiner? 1 Yes 2 No 3 Probably 4 Unit 24a. Was an autopsy findings an prior to completion of cardeal? 1 Yes 2 No 3 Probably 4 Unit 24a. Was an autopsy findings an prior to completion of cardeal? 1 Yes 2 No 3 Probably 4 Unit 24a. Was an autopsy findings an prior to complete of cardeal? 1 Yes 2 No 3 Probably 4 Unit 24a. Was an autopsy findings an prior to complete of cardeal? 1 Yes 2 No 3 Probably 4 Unit 24a. Was an autopsy findings an autopsy findings and prior to complete of cardeal? 1 Yes 2 No 3 Probably 4 Unit 24a. Was an autopsy findings an autopsy findings and prior to complete of cardeal? 1 Yes 2 No 3 Probably 4 Unit 24b. Were autopsy findings and prior to complete of cardeal? 1 Yes 2 No 3 Probably 4 Unit 24a. Was an autopsy findings and prior to complete of cardeal? 1 Yes 2 No 3 Probably 4 Unit 24b. Were autopsy findings an autopsy findings and prior to complete of cardeal? 1 Yes 2 No 3 Probably 4 Unit 24b. Were autopsy findings an autopsy findings and prior to complete of cardeal? 1 Yes 2 No 3 Probably 4 Unit 24b. Were autopsy findings and prior to complete of cardeal? 1 Yes 2 No 3 Probably 4 Unit 25c. Place of Death (Check only one) 28d. Describe how injury occurred 26c. Injury at Nork? 28d. Describe how injury occurred 27d. Accrding 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. D	Sici		1 ☐ Yes 2 ☐ No	4 Pregnant at							Month	Day Year
1 Yes 2 No 3 Probably 4 Ur 24a. Was an autopsy findings an autopsy performad? 1 Yes 2 No 3 Probably 4 Ur 24a. Was an autopsy performad? 1 Yes 2 No 3 Probably 4 Ur 24b. Were autopsy findings an autopsy prior to completion of cat death? 1 Yes 2 No 3 Probably 4 Ur 25c. Was case referred to medical examiner? 1 Yes 2 No 3 Probably 4 Ur 26d. Place of Death (Check only one) 27c. Manner of Death Month, Day Year 28b. Time of Injury 28c. Injury at Work? 28c. Injury at Work? 28d. Describe how injury occurred 28d. Describe how in				contributing to death b	ut not result	ting in the ur	derhing cause o	wan in Part I	23e Did to	abacco u	ise contribute t	o the cause of deat
24a. Was an autopsy performed? 1 Yes 2 No No Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: A Nursing Home 5 Residence 6 Other (Specify) 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: A Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Natural S Pending Investigation 2 A coident 3 Suicide 4 Homicid			3			ang ar aro di	donying oadse g	Work at t art i.				
25. Was case referred to medical examiner? 1 Yes 2 No	0	-							:			utaney findings avai
25. Was case referred to medical examiner? 1 Yes 2 No	et	· -			-				autop	isy mad?	prior to death?	completion of cause
Second Properties Seco	ompiet	1						26 Place of Dea			1 L Yes	s 2∐No
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury 28b. Time of Injury M 1 Yes 2 No 28b. Linjury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurr	C	examiner/ O 1 Yes 2X No Hospital: 1 Innatient 2X FR/Outnatient 3 DOA Other.									6 □Other (Spe	ecify)
29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	o Be C			28a. Date of Inju- (Month, Da	ry 2 y Year) 2		28c. Inj	ury at ork?	28d. Describe h	now injur	y occurred	
29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	To Be C			he								
29a. Certifier (Chack only one) 29a. Certifier (Chack only one) 29a. Certifier (Chack only one) 29a. Certifier (Chack only one) 29a. Certifier (Chack only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	To Be C		2 0 1 100 100 11		ury - At hom c. <i>(Specify)</i>	ne, farm, str	eet, factory, office					ural Route Number,
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	To Be C		3 ☐ Suicide 6 ☐ Could not I	building, etc						20112		
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Certification: To Be C	2	3 Suicide 6 Could not to determined	building, etc		ladaa daath	coourad at the	ima data and place				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Certification: To Be C	2	3 Suicide 4 Homicide 6 Could not to determined 29a. Certifier (Check only) 2 Medical Exa	Physician: To the best aminer: On the basis of	of my knowl	ledge, death on and/or inv	occurred at the restigation, in my	time, date and place opinion, death occu	rred at the time,	date and	I place, and due	s stated. e to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	edical Certification: To Be C	2	3 Suicide 4 Homicide 6 Could not to determined 29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	Physician: To the best aminer: On the basis of	of my knowl	iedge, death on and/or inv	restigation, in my	opinion, death occu	rred at the time,	date and	I place, and due	e to the cause(s)
	edical Certification: To Be C	2	3 Suicide 4 Homicide 6 Could not to determined 29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	Physician: To the best aminer: On the basis of	of my knowl	ledge, death on and/or inv	restigation, in my	opinion, death occu	rred at the time,	date and 29d. Dat	I place, and due	th, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For	State of Marylan				dental Hygiene	•	
			State Registrar Decedent's Name (First, Middle, Las		Cer	tificate o	of Death	Reg. No	2005	25498
	Physici		T_S C C C	Clark	50			2. Date of Death Month Da	Y 2005	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give		7	4b. City, Town	n, or Location of Death		County of Death	1 3
			515- W. A		enue	Ca	Mbridg		ORche	
	Funeral Director		5. Social Security Number 6. S	9X DM 2□ F 7/Age (In yrs.	Yrs.	If Under 1 Yes Months Day		8. Date of Birth Month, Day, Year		pplace (State or Foreign untry)
	pu *		Usual Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Lo	nation		,	700	3777
	death with the Maryland rms 23a or 28a-f show finust be ricdiffed at	tor		1	^	bridg	10.			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
5	th the M or 28a-f s rediffs	Funeral Director	10e. Street and Number	103101	Carri	10f. Zip Code		10g. Ci	tizen of What Cor	untry?
3	s 23a	ral	515 W. APP	leby Aven	ye.	1 2	2/6/3		USA	
	after dea or Items	Fune	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No	l II		of Hispanic Origin? (Sp uban, Mexican, Puerto ,	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
Maryland 21215-0036	72 hours after natural', or Ite	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		☐ Yes 2121	No Specify:		Specify: B/C	ack
15-(Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	lent's Usual Oct kind of work doi DO NOT use ret	ne during most of work	ting 16b. K	ind of Business/l	ndustry
212	should be filed within and Mental Hygiene. marked other than matic event, the M	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	M	achir	nist	MO	inufac	turing
and	ould be file Mental Hy arked oth atic event	Be	17. Father's Name (First, Middle, Last)	1 - 1			18. Mother's Nam	e (First, Middle, Maider	Sumame)	J
aryla	2 should and Mer is mark aumatic	2	19a. Informant's Name/Relationship (1	450 Type, Print)	19b. Mailin	a Address (Stre	eet and Number or Rur	al Route Number, City	VS or Town, State, Z	in Code)
	12 H		Rosalie	Clark	515	W. Ar	pleby AI	ie, Cambr	idge N	10,21613 Town, State
Baltimore,	e ° ± 5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	nemoval nom State		sition (Name of natory or other p	place)			
ij	permit. Pa Departmen Important: any injury once.		 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen 			PMet.	ery // 2	5/05 Ca	Mbridg	e, 100,
Ba	permit. Departimport any inj		1 Janelle	C. Henry	Y H	enry TIO WI	Funeral	Home, P.A.	bridge,	MD-2/613
			23a. Part1. Enter the disease, or composhock, or heart failure. List only	olications that caused the deal	n. Do not ente	or the mode of d	lying, such as cardiac	or respiratory arrest,	37	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Mutasta. Due to (or as a conseq		rostat	1 Canc	er		5/1507 tarid 5/5417
	Examiner		Sequentially list conditions	h	derice orj.					
	led sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of					
,	executed in and ial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):			·		
8760,	icate be execul physician and s the burial-trar	dlcai	· ·	d						
9	eath certific attending p	d) ⊢	IF FEMALE:	23c. If yes, outcome of pregna	incv				20d Date of daily	
Box	law requires that the death certific as been signed by the attending p 2 should be detached for use as	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	I death 3	Ectopic pregnar Other (specify)			23d. Date of deliv Month	Day Year
P.0	that the died by the detached	Phys	9 Unknown	9∐ Unknown	Min of the Alexander			00 01411		
ds,	w requires the been signer should be considered.		Part II. Other significant conditions of	ontributing to death but not resi	uiting in the un	ideriying cause	given in Part I.	1 Yes 2	_	the cause of death?
Records,	as been 2 should	ompleted					.,	24a. Was an	24b. Were aut	opsy findings available
II Re	The ate has page	Com						autopsy performed? 1 ☐ Yes 2 🔊 No	death?	ompletion of cause of 2 No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othor	h (Check only one)		
of		n: To	27. Manner of Donth	28a. Date of Injury	ER/Outpatient 28b. Time of	28c. In	4 Divursing Ho	me 5 K Residence 28d. Describe how inju-		ify)
sion	Attending r death. sctor: After y the fune	atlo	1 Natural 5 Pending 2 Accident investigation		Injury		Vork? □Yes 2□No			
Division	or Att after d Direct in by 1	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	eet, factory, offic	ce	28f. Location (Street ar City or Town, State		ral Route Number,
_	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Ph	ysician: To the best of my kno	wledge, death	occurred at the	time, date and place,	and due to the cause(s) and manner as	stated.
	the Hin 24 the Fi	Medical	UTO)	iner: On the basis of examina and manner stated.	tion and/or inv					
	To To		29b. Signature and title of certification	USGIANT	_	29c. Lice	ense number	29d. Da	te signed (Month,	O() 5
			30. Name and address of person who	completed cause of death (Item	23a) (Type, F			1	(4.0)	
			Eric Ji W	idmater M	.01	503 B	yrn St. C	om Oridge,	V40 Z	1613
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	M A	marks 2				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Crandell Nelson July 18 2005 Reed /Medical 3:16 a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1**∑**M 2□F Director Yrs. 74 Sep. 20, 1930 214-30-5021 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 77 is marked other than "natural", or flems 23e or 28a-f show traumatic event, the Medical Exertities matter matter national 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No MD Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death 5811 Crandell Road 20711 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 1 Yes, Give Year or Dates: 1955–57 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or fte 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 1 ☐ Yes 21 No 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 carpenter construction 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First Middle Maiden Surname) Crandell, Sr. Reed Pearl Sherbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any injury or other traum once. 5811 Crandell Rd., Lothian, MD Rosalie G. Crandell, wife 20711 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 07-21-2005 Lothian. 21. Signature of Funeral Service 4 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Rausch Funeral Home, P.A., Owings, MD 20736 Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) sudden cardiac death /Medical Due to (or as a consequence of): Examiner coronary artery disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner certificate be executed use as the burial-transit that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. | the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ pe hypertrophic cardiomyopathy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed elevated cholesterol 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate Division of Vital 1 Yes 2**X** No 1 ☐ Yes 2 ☐ No the Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3XDOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending after death. Director: Af investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 T Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) D41816 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Id Solomons Island Rd Annagalis 32. Registra Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

JUL 2 0 2005

MD 2HU)

DIETZ CHARLENE ANN Baltimore, Maryland 21215-0036

Angold me lok as is	Division of Vital Records, P.O. Box 68760,

			State of Maryland / De	Indelible Ink. Ensure All Co epartment of Health and Ment		
			1 - State Registrar	Certificate of Death	Reg. N	
H	Physici /Medic	cal	1. Decedent's Name (First, Middle, Last) CHARLENE ANN DIETZ	Jill	ate of Death onth 1423	Year 1400 M
•	Examir	er	4a. Facility Name (If not institution, give street and number) Memorial Hospital	4b. City, Town, or Location of Death EASTON	4	TAIbot
	Funeral Director		5. Social Security Number 220-70-2700 6. Sex 1 M 2 F 7. Age (In yrs. last birthe	day) If Under 1 Year If Under 24 Hrs. 8. Days Hours Min. AP	ate of Birth fonth Day, Yea R 12 19	
poelva	how		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of		· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits
the Ma	28a-f s	Director	MD TALBOT E. 10e. Street and Number	ASTON	100.0	XXYes 2 No
ath with	23a or			21601	109.0	USA
.0036 hours after death with the Maryland	ial Hygiene. d other then "naturel", or items 23a or 28a-f show event, It a Medical Examinar must be notified at	by Funeral	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican 1 Yes Yes No Specify:	es or No- etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
CZ Office CZ office	ene. then "na he Medic	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ecedent's Usual Occupation Give kind of work done during most of working fe. DO NOT use retired) HOMEMAKER		Kind of Business/Industry OWN HOME
Maryland 2		To Be C	17. Father's Name (First, Middle, Last) RICHARD DIETZ	18. Mother's Name (First DORIS VA	, Middle, Maide N HORN	on Sumame)
	h ar 7 is trau			failing Address (Street and Number or Rural Rout 66 KATHY STREET EASTON		
ore 18	E e e		1 Burial 2 Cremation 3 Removal from State	isposition (Name of Crematory or other place)		Location - City or Town, State
	Department important: if any injury or once.		`4 □Donation 5 □Other (Specify) MD VET. 21. Signature of Funeral Service Licensee	ERANS CEMETERY 7/27/200		RLOCK, MARYLAND
n a	E E E E		23a. Part 1. Enter the disease, or complications that caused the death. Do not	FELLOWS, HELFENBEIN & 200 S. HARRISON ST EAS	STUN, MI	D 21601
E	Medical Xaminer	ner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	rhosis	andory unrest,	Approximate Interval Between Onset and Death
58/50, ificate be executed	8 0	edical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last C			
Geath cert	igned by the attending physic be detached for use as the t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
Hecords, P.O.	signed t	by	Tarin. Other significant contations continuing to death but not resulting in the	\ .*	3e. Did tobacco	use contribute to the cause of death?
ecords,	s been sign	Completed	Charle Cosmuctive Was	ch sease	la. Was an	24b. Were autopsy findings available
				1[autopsy performed? ☐ Yes 2 🗷 N	prior to completion of cause of death? 1 □ Yes 2 □ No
T VITAL	uis certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ♣ No Hospital: 1 ♣ Inpatient 2 ☐ ER/Outpa	26. Place of Death (Checate attent 3 DOA Other: 4 Nursing Home 5		6 □Other (Specify)
Or Attending Physician:	death. ctor: After this y the funeral dir	Certification;	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury (Month, Day Year)	e of 28c. Injury at 28d. D	escribe how inju	
	after death i Director: , d in by the f	ertific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office 28f. Lo	cation (Street a ty or Town, Stat	nd Number or Rural Route Number, e)
e Hospits	within 24 hours aff To the Funeral DI completely filled in	ledical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, d 2 Medical Examiner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place, and du or investigation, in my opinion, death occurred at the	e to the cause(s	s) and manner as stated. Id place, and due to the cause(s)
Total	withii To th	ž	29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month, Day, Year)
((2)		30. Name and address of person who completed suse of death (Item 23a) (Ty	DØD59762 pe. Print) Easton, My		(4-110)
	Sta Registr	-	31. Date filed (Month, Day, Year) JUL 2 5 2005 Registrar's Signature	Cir.		